Chapter 182-544 WAC
VISION CARE

WAC

VISION CARE—CLIENTS TWENTY YEARS OF AGE AND YOUNGER

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VISION CARE—CLIENTS TWENTY YEARS OF AGE AND YOUNGER

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

(a) Covered;

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

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

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

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

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

(3) The department 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. The department evaluates these requests on a case-by-case basis to determine whether they are medically necessary, according to the process found in WAC 388-501-0165.

[WSR 11-14-075, recodified as § 182-544-0010, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. WSR 08-14-052, § 388-544-0010, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-544-0010, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. WSR 05-13-038, § 388-544-0010, filed 6/6/05, effective 7/7/05.]

WAC 182-544-0050 Vision care—Definitions. The following definitions and those found in 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 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 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 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 written approval for a specific vision care service(s). The department's approval is based on medical necessity and must be received before the service(s) are provided to clients as a precondition for payment.

"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.

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WAC 182-544-0100 Vision care—Eligible clients—Twenty years of age and younger. This section applies to eligible clients who are twenty years of age and younger.

(1) Vision care is available to clients who are eligible for services under the following medical assistance programs:

(a) Categorically needy program (CN or CNP);

(b) Categorically needy program - State children's health insurance program (CNP-SCHIP);

(c) Children's health care programs as defined in WAC 388-505-0210;

(d) Limited casualty program - Medically needy program (LCP-MNP);

(e) Disability lifeline (formerly general assistance (GA-U/ADATSA)) (within Washington state or designated border cities); and

(f) Alien emergency medical (AEM) as described in WAC 388-438-0115, when the medical services are necessary to treat a qualifying emergency medical condition only.

(2) Eligible clients who are enrolled in a department contracted managed care organization (MCO) are eligible under fee-for-service for covered vision care that are not covered by their plan and subject to the provisions of this chapter and other applicable WAC.

[WSR 11-14-075, recodified as § 182-544-0100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-11-016, § 388-544-0100, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. WSR 08-14-052, § 388-544-0100, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. WSR 05-13-038, § 388-544-0100, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. WSR 01-01-010, § 388-544-0100, filed 12/6/00, effective 1/6/01.]

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

(a) Meet the requirements in chapter 388-502 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 designated supplier as published in the department's current vision care billing instructions; and

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

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

(a) Ophthalmologists;

(b) Optometrists;

(c) Opticians; and

(d) Ocularists.

[WSR 11-14-075, recodified as § 182-544-0150, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. WSR 08-14-052, § 388-544-0150, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. WSR 05-13-038, § 388-544-0150, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. WSR 01-01-010, § 388-544-0150, filed 12/6/00, effective 1/6/01.]

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

[WSR 11-14-075, recodified as § 182-544-0250, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-11-016, § 388-544-0250, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. WSR 08-14-052, § 388-544-0250, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. WSR 05-13-038, § 388-544-0250, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. WSR 01-01-010, § 388-544-0250, filed 12/6/00, effective 1/6/01.]

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

(1) The department 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 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 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(1)) limited to once every two years for eligible clients twenty years of age or younger.

[WSR 11-14-075, recodified as § 182-544-0300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-11-016, § 388-544-0300, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.08.090,

74.09.510, 74.09.520. WSR 08-14-052, § 388-544-0300, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. WSR 05-13-038, § 388-544-0300, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. WSR 01-01-010, § 388-544-0300, filed 12/6/00, effective 1/6/01.]

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

(1) The department covers durable or flexible frames, without prior authorization, when the eligible client has a diagnosed medical condition that has contributed to two or more 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 designated supplier.

(2) The department 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) Incidental repairs to a client's eyeglass frames. 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 cost for replacement frames and a fitting fee.

(c) Replacement eyeglass frames that have been lost or broken.

[WSR 11-14-075, recodified as § 182-544-0325, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-11-016, § 388-544-0325, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. WSR 08-14-052, § 388-544-0325, filed 6/24/08, effective 7/25/08.]

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

(1) The department 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).

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

(3) The department covers, without prior authorization, the following 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 spherical refractive correction of plus or minus six diopters or greater; or

(ii) 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, 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 optic neuritis;

(k) Rare photo-induced epilepsy conditions; or

(l) Retinitis pigmentosa.

(5) The department covers replacement lenses for eligible clients without prior authorization when the lenses are lost or broken.

(6) The department covers replacement lenses, without prior authorization, when the eligible client meets one of the 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 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:

(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.

[WSR 11-14-075, recodified as § 182-544-0350, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-11-016, § 388-544-0350, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. WSR 08-14-052, § 388-544-0350, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, and 42 C.F.R. 440.120 and 440.225. WSR 05-17-153, § 388-544-0350, filed 8/22/05, effective 9/22/05; WSR 05-13-038, § 388-544-0350, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. WSR 01-01-010, § 388-544-0350, filed 12/6/00, effective 1/6/01.]

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

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

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

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

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WAC 182-544-0560 Vision care—Authorization. (1) The department 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 as specified in the department'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 published vision care billing instructions. The appropriate EPA number must be used when the provider bills the department.

(c) Upon request, a provider must provide documentation to the department 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 rules, billing instructions, and numbered memoranda.

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

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

(6) The department 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.

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

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WAC 182-544-0575 Vision care—Noncovered eyeglasses and contact lenses. (1) The department 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 contract limitations (e.g., frames that are not available through the department's contract or noncontract frames or lenses for which the client or other person pays the difference between the department's payment and the total cost).

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

[WSR 11-14-075, recodified as § 182-544-0575, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 11-11-016, § 388-544-0575, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. WSR 08-14-052, § 388-544-0575, filed 6/24/08, effective 7/25/08.]

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

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

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

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