WAC 182-544-0560 Vision care—Authorization. (1) The medicaid agency requires providers to obtain authorization for covered vision care services as required in this chapter.

(a) For prior authorization (PA), a provider must submit a written request to the agency as specified in the 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 agency's published vision care billing instructions. The appropriate EPA number must be used when the provider bills the agency.

(c) Upon request, a provider must provide documentation to the 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 agency's rules and billing instructions.

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

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

(6) The 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 182-501-0169.

(7) 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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-14-067, § 182-544-0560, filed 6/29/17, effective 7/30/17. WSR 11-14-075, recodified as § 182-544-0560, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. WSR 08-14-052, § 388-544-0560, filed 6/24/08, effective 7/25/08.]