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

(a) Covered;

(b) Within the scope of the client's benefit package;

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

(d) Authorized, as required within this chapter, chapter 182-501 WAC, and the agency's published billing instructions; and

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

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

(3) The 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 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 in WAC 182-501-0165.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-14-067, § 182-544-0010, filed 6/29/17, effective 7/30/17. 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.]