Washington State Health Care Authority

Washington Apple Health (Medicaid)

Vision Hardware Program Billing Guide

(For clients age 20 and younger)

July 1, 2022

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an HCA rule arises, HCA rules apply.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at **askmedicaid@hca.wa.gov**.

About this guide[1]

This publication takes effect **July 1, 2022**, and supersedes earlier billing guides to this program. Unless otherwise specified, the program(s) in this billing guide are governed by Chapter 182-544 WAC.

The Health Care Authority 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.

Refer also to HCA's **ProviderOne billing and resource guide** for valuable information to help you conduct business with the Health Care Authority.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's **provider alerts webpage**.

To access provider documents, go to HCA's **provider billing guides and fee schedules webpage.**

Where can I download HCA forms?

To download an HCA form, see HCA's **Forms & Publications webpage**. Type only the form number into the Search box (Example: 13-835).

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[1] This publication is a billing instruction.

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Copyright disclosure

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Client eligibility – Clients who are not enrolled in an HCA-contracted managed care plan for physical health services	Clarified who pays if a client received Medicaid-covered services before being automatically enrolled in a BHSO	Program enrollment clarification
Client eligibility – Integrated managed care	Revised paragraph to reflect enrollment in an integrated managed care plan	Clarification
Client eligibility – American Indian/Alaska Native (AI/AN) Clients	Created new subsection and moved this information out of the *Integrated managed care* section	Create a stand-alone section for just AI/AN clients

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Resources Available

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See HCA's ProviderOne Resources webpage
Finding out about payments, denials, claims processing, or HCA managed care organizations	See HCA's ProviderOne Resources webpage
Electronic billing	See HCA's ProviderOne Resources webpage
Finding HCA documents (e.g., billing guides and fee schedules)	See HCA's ProviderOne Resources webpage
Private insurance or third-party liability, other than HCA managed care	See HCA's ProviderOne Resources webpage
Where do I order hardware?	Order hardware from HCA's contractor: **CI Optical** 11919 West Sprague Avenue PO Box 1959 Airway Heights, WA 99001-1959 Customer Service Telephone 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?	Washington State Department of Services for the Blind Lilac Blind Foundation **(Spokane)**

Topic	Contact Information
How do I obtain prior authorization (PA) or a limitation extension (LE)?	Providers may submit their requests online (See HCA's **Prior Authorization** webpage) or by submitting the request in writing. Written or faxed requests for prior authorization or limited extensions must include: • 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 HCA's **Prior Authorization** webpage. For information about downloading HCA forms, see **Where can I download HCA forms**?

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC and WAC 182-544-0050 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.

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, HCA 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, HCA generally approves only those lenses that are designed to be worn as daily wear (remove at night).

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.

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.

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 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.

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About the Program

What is the scope of the vision hardware program?

(Chapter 182-544 WAC)

The vision hardware program is available 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?

HCA covers the vision hardware listed in this billing guide, according to HCA rules and subject to the limitations and requirements found in the coverage section of this guide. HCA 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 provider requirements must be met?

Eye care providers who are enrolled or contracted with HCA 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 HCA clients from HCA's designated supplier. See Ordering Vision Hardware
- Return all unclaimed hardware and contact lenses to HCA's designated supplier using a postage-paid envelope furnished by the supplier

Note: Check the accuracy of all prescriptions and order forms submitted to HCA's contracted provider.

Who may provide vision hardware to HCA clients?

The following providers are eligible to enroll or contract with HCA to provide and bill for vision hardware furnished to eligible clients:

- Ophthalmologists
- Optometrists
- Opticians
- Ocularists

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Client Eligibility

Who is eligible?

Eligible clients who are age 20 and younger 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 webpage for an up-to-date listing of benefit packages.

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's Apple Health managed care page for further details.

> **It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.**

Limited coverage

HCA 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, HCA pays for vision hardware only when Medicare allows the service and has made a payment or applied the payment to the client's deductible.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has 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 HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health**. For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in HCA's ProviderOne Billing and Resource Guide.

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

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

Note: Patients who are not Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website.
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 the Washington Healthplanfinder's website or call the Customer Support Center.

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Medicaid-eligible clients are enrolled in one of HCA'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, fitting fees, refractions, and visual fields** must be requested and provided directly through the client's MCO.

> **Note**: On July 1, 2021, HCA updated the ProviderOne system to direct claims for vision hardware fitting fees and some prescription fees for clients enrolled in a managed care organization (MCO) to the client's MCO for payment. For claims with dates of service on and after July 1, 2021, all medical providers must bill specific codes directly to the MCO. For additional information on specific codes, see Coverage Table.

- **Eyeglass frames, lenses, and contact lenses** must be ordered from HCA'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 HCA-contracted MCO.

All medical services covered under an HCA-contracted MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

> **Note**: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

Managed care enrollment

Most Apple Health (Medicaid) clients are enrolled in HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination. Providers must check eligibility to determine enrollment for the month of service.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care.

Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's **Get Help Enrolling** page.
- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:

  Go to **Washington Healthplanfinder website**.

- **Available to all Apple Health clients:**
  - Visit the **ProviderOne Client Portal website**:
  - Request a change online at **ProviderOne Contact Us** (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's **Apple Health Managed Care** webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS Medicaid program will reimburse providers for the covered services. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

For full details on integrated managed care, see HCA's **Apple Health managed care webpage** and scroll down to "Changes to Apple Health managed care."

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

> These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care**."

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care Medical Team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's **Mental Health Services Billing Guide**, under *How do providers identify the correct payer*?

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) **American Indian/Alaska Native webpage**.

Coverage

What services are covered?

Ocular Prosthetics
(WAC 182-531-1000)

HCA 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 Coverage Table for more information on coverage for ocular prosthetics and the Outpatient Prospective Payment System (OPPS) and Outpatient Hospitals fee schedule.

Vision therapy
HCA covers orthoptics and vision therapy. See the Physician-Related Services/Healthcare Professional Services Medicaid Billing Guide for coverage criteria.

HCA 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)
HCA covers eyeglasses once in a calendar year 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

If the above criteria are not met, prior authorization (PA) is required.

Eyeglasses for clients with accommodative esotropia or strabismus

HCA covers eyeglasses (frame and lenses), for eligible clients with a diagnosis of accommodative esotropia or any strabismus correction. In this case, the limitations listed in **Eyeglasses (Frames and Lenses)** do not apply.

Back-up eyeglasses

HCA 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.

Lost or broken frames or lenses

HCA covers up to two replacement frames and up to four replacement lenses in a calendar year, if they have been lost or broken, without authorization. If additional replacement frames or replacement lenses are needed, a provider must request a limitation extension (LE). See **How do I request a limitation extension?**

> **Note**: If a client loses their eyeglasses, one replacement frame and two lenses for the frame count towards the per calendar year replacement total. Therefore, the client would have one replacement frame and two lenses remaining in their yearly allowed amount. Providers must document the reason for replacement in the client file.
>
> **Note**: Frames are covered by a one-year warranty against manufacturer defects.

Durable or flexible frames

HCA covers durable or flexible frames when the eligible client has a diagnosed medical condition that contributes to broken eyeglass frames. To receive payment, the provider must:

- Follow HCA's expedited prior authorization (EPA) process. See **EPA# 870000619 and EPA# 870000620** in the **authorization** section of this guide.
- Document reasons that the standard CI Optical frame is not suitable for the client. For example, a reason may be that the client is age five or younger.
- Order the **durable** or **flexible** frames through HCA's designated supplier

See **Lost or broken frames or lenses** for replacement frames for clients who do not have a diagnosed medical condition that contributes to broken eyeglass frames.

Coating of frames and incidental repairs

HCA covers:

- 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.
- Four incidental repairs to a client's eyeglass frames in a calendar year. 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 HCA's cost for replacement frames and a fitting fee.

Eyeglass lenses

HCA covers the following plastic scratch-resistant eyeglass lenses.

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

> **Note**: HCA's contractor supplies **all** plastic eyeglass lenses with a scratch-resistant coating. Eyeglass lenses must be placed into a frame that is, or was, purchased by HCA.

High index eyeglass lenses

HCA covers high index lenses with PA/EPA 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; or
- 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 the **authorization** section of this guide.

Plastic photochromatic lenses

HCA covers plastic photochromatic lenses. The eligible client's medical need must be diagnosed and documented as one of the following:

- Ocular Albinism
- Retinitis pigmentosa

Use the appropriate ICD-10 code for the medical condition that allows the client to receive plastic photochromatic lenses.

Polycarbonate lenses

HCA covers polycarbonate lenses. The eligible client's medical need must be diagnosed and documented as one of the following:

- Amblyopia
- Attention deficit hyperactivity disorder (ADHD)
- Autism
- Bipolar
- Blind in one eye and needs protections for the other eye, regardless of whether a vision correction is required
- Cerebral palsy
- Developmental delay
- Down syndrome
- Infants and toddlers with motor ataxia
- Multiple sclerosis
- Schizophrenia
- Seizure disorder
- Strabismus

Use the appropriate ICD-10 code for the medical condition that allows the client to receive polycarbonate lenses.

Replacement of bifocal or trifocal lenses

HCA covers 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

HCA covers the tinting of plastic lenses as follows:

- The tinting must be performed by HCA's designated lens supplier
- 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:
    - Blindness
    - 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

Use the appropriate ICD-10 code for the medical condition that allows the client to receive tinted plastic lenses.

Replacement lenses due to refractive change

HCA covers replacements lenses with PA/EPA 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 HCA's expedited prior authorization (EPA) process (see **EPA# 870000622** in the **authorization** section of this guide).

- **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 HCA's EPA process. See **EPA# 870000624** in the **authorization** section of this guide.

Contact lenses

HCA covers contact lenses 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.

HCA 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	Use the appropriate ICD-10 code for the medical condition that allows the client to receive contact lenses.
Myopia	Use the appropriate ICD-10 code for the medical condition that allows the client to receive contact lenses.

Note: HCA's opinion is that the prolonged use of overnight wear may increase the risk of corneal swelling and ulceration. Therefore, HCA 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

HCA covers soft toric contact lenses 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. 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.

Medical Problems	ICD Diagnosis Code
Astigmatism	Use the appropriate ICD-10 code for the medical condition that allows the client to receive soft toric contact lenses.

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

HCA covers contact lenses 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	Use the appropriate ICD-10 code for the medical condition that allows the client to receive contact lenses.

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

Medical Problems	ICD Diagnosis Code
Aphakia	Use the appropriate ICD-10 code for the medical condition that allows the client to receive contact lenses.
Keratoconus	Use the appropriate ICD-10 code for the medical condition that allows the client to receive contact lenses.
Corneal softening	Use the appropriate ICD-10 code for the medical condition that allows the client to receive contact lenses.

- Therapeutic contact bandage lenses only when needed immediately after eye injury or eye surgery

Lost or damaged contact lenses

HCA 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

HCA covers replacement contact lenses for eligible clients 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.

Corneal Cross-Linking Surgery

For information regarding corneal cross-linking surgery, please see the **Physician-Related Services/Health Care Professional Services Billing Guide**.

What is not covered?

HCA 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 HCA's contract limitations. For example:
    - Frames that are not available through HCA's contract
    - Noncontract frames or lenses for which the client or other person pays the difference between HCA'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, HCA publishes only the official, brief Current Procedural Terminology (CPT®) procedure code descriptions. To view the entire description, see the current CPT® book.

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

Note: On July 1, 2021, HCA updated the ProviderOne system to direct claims for vision hardware fitting fees and some prescription fees for clients enrolled in a managed care organization (MCO) to the client's MCO for payment. For clients enrolled in fee-for-service, continue to bill through the ProviderOne fee-for-service system.

For claims with dates of service on and after July 1, 2021, all medical providers must bill the specific codes listed below directly to the MCO when the client is enrolled in an MCO. For clients enrolled in fee-for-service, continue to bill through the ProviderOne fee-for-service system. CPT® codes affected by the change are 92071, 92072, 92310, 92311, 92312, 92313, 92340, 92341, 92342, 92352, 92353, 92354, and 92355.

No change was made in the system for the prescription and repair CPT® codes below. Continue to bill HCA through ProviderOne for all clients for these codes whether the client is enrolled in an MCO or in fee-for-service. These CPT® codes include 92314, 92315, 92316, 92317, 92370, and 92371.

Contact lens services

CPT Code	Modifier	Short Description	PA	Policy/Comments
92071		Contact lens fitting for tx		1 fitting in a calendar year. If client is enrolled in an MCO, bill the MCO.
92072		Fit contac lens for managmnt		2 fittings in a calendar year. Refer to **contact lenses** for diagnosis range limitations. If client is enrolled in an MCO, bill the MCO.

Spectacle fitting fees, monofocal

CPT Code	Modifier	Short Description	PA	Policy/Comments
92340		Fit spectacles monofocal	No	If client is enrolled in an MCO, bill the MCO. If client is enrolled in fee-for-service, bill through ProviderOne.
92352		Fit aphakia spectcl monofocl	No	If client is enrolled in an MCO, bill the MCO. If client is enrolled in fee-for-service, bill through ProviderOne.

Spectacle fitting fees, bifocal

CPT Code	Modifier	Short Description	PA	Policy/Comments
92341		Fit spectacles bifocal	No	If client is enrolled in an MCO, bill the MCO. If client is enrolled in fee-for-service, bill through ProviderOne.

Spectacle fitting fees, multifocal

CPT Code	Modifier	Short Description	PA	Policy/Comments
92342		Fit spectacles multifocal	No	If client is enrolled in an MCO, bill the MCO. If client is enrolled in fee-for-service, bill through ProviderOne.
92353		Fit aphakia spectcl multifoc	No	If client is enrolled in an MCO, bill the MCO. If client is enrolled in fee-for-service, bill through ProviderOne.

Other

CPT Code	Modifier	Short Description	PA	Policy/Comments
92354		Fit spectacles single system	Yes	If client is enrolled in an MCO, bill the MCO. If client is enrolled in fee-for-service, bill through ProviderOne.
92355		Fit spectacles compound lens	Yes	If client is enrolled in an MCO, bill the MCO. If client is enrolled in fee-for-service, bill through ProviderOne.
92370		Repair & adjust spectacles	No	Bill fee-for-service regardless of MCO enrollment.

CPT Code	Modifier	Short Description	PA	Policy/Comments
92371		Repair & adjust spectacles	No	Bill fee-for-service regardless of MCO enrollment.

Note: Fitting fees are not currently covered by Medicare and may be billed directly to HCA without attaching a Medicare denial.

General Ophthalmological Services

CPT Code	Modifier	Short Description	PA	Policy/Comments
92002		Eye exam new patient	No	
92004		Eye exam new patient	No	
92012		Eye exam establish patient	No	
92014		Eye exam&tx estab pt 1/>vst	No	

Special Ophthalmological Services

CPT Code	Modifier	Short Description	PA	Policy/Comments
92015		Determine refractive state	No	
92018		New eye exam & treatment	No	
92019		Eye exam & treatment	No	

CPT Code	Modifier	Short Description	PA	Policy/Comments
92020		Special eye evaluation	No	
92025		Corneal topography	Yes	Requires PA/EPA. See Physician-Related Health Care Services Billing Guide. Limit 2 per calendar year.
92025	TC	Corneal topography	Yes	Requires PA/EPA. See Physician-Related Health Care Services Billing Guide. Limit 2 per calendar year.
92025	26	Corneal topography	Yes	Requires PA/EPA. See Physician-Related Health Care Services Billing Guide. Limit 2 per calendar year.
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	

CPT Code	Modifier	Short Description	PA	Policy/Comments
92082	26	Visual field examination(s)	No	
92083		Visual field examination(s)		
92083	TC	Visual field examination(s)	No	
92083	26	Visual field examination(s)	No	
92100		Serial tonometry exam(s)	No	
92132		Cmptr ophth dx img ant segment		
92132	TC	Cmptr ophth dx img ant segment		
92132	26	Cmptr ophth dx img ant segment		
92133		Cmptr ophth img optic nerve		
92133	TC	Cmptr ophth img optic nerve		
92133	26	Cmptr ophth img optic nerve		
92134		Cptr ophth dx img post segmt	Yes	PA or EPA required. Limited to 12 per calendar year. EPA #870000051. See Physician-Related Health Care Services Billing Guide.
92134	TC	Cptr ophth dx img post segmt	Yes	PA or EPA required. Limited to 12 per calendar year. EPA #870000051. See Physician-Related Health Care Services Billing Guide.
92134	26	Cptr ophth dx img post segmt	Yes	PA or EPA required. Limited to 12 per calendar year. EPA #870000051. See Physician-Related Health Care Services Billing Guide.

CPT Code	Modifier	Short Description	PA	Policy/Comments
92136		Ophthalmic biometry	No	
92136	TC	Ophthalmic biometry	No	
92136	26	Ophthalmic biometry	No	

Ophthalmoscopy

CPT Code	Modifier	Short Description	PA	Policy/Comments
92201		Opscpy extnd rta draw uni/bi		
92202		Opscpy extnd on/mac draw		
92230		Eye exam with photos	No	A report is required with image.
92235		Fluorescein angrph uni/bi	No	A report is required with image.
92235	TC	Fluorescein angrph uni/bi	No	
92235	26	Fluorescein angrph uni/bi		
92240		Icg angiography uni/bi	No	
92240	TC	Icg angiography uni/bi	No	
92240	26	Icg angiography uni/bi	No	
92250		Eye exam with photos	No	A report is required with image. Code not covered for routine eye exams.

CPT Code	Modifier	Short Description	PA	Policy/Comments
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	

Other specialized services

CPT Code	Modifier	Short Description	PA	Policy/Comments
92265		Eye muscle evaluation	No	
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	
92283		Color vision examination	No	
92283	TC	Color vision examination	No	
92283	26	Color vision examination	No	
92284		Dark adaptation eye exam	No	

CPT Code	Modifier	Short Description	PA	Policy/Comments
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	
92287	TC	Internal eye photography	No	
92287	26	Internal eye photography	No	

Contact lens services

CPT Code	Modifier	Short Description	PA	Policy/Comments
92310		Contact lens fitting	No	If client enrolled in an MCO, bill the MCO. If client is enrolled in fee-for-service, bill through ProviderOne.
92311		Contact lens fitting	No	If client enrolled in an MCO, bill the MCO. If client is enrolled in fee-for-service, bill through ProviderOne.
92312		Contact lens fitting	No	If client enrolled in an MCO, bill the MCO. If client is enrolled in fee-for-service, bill through ProviderOne.

CPT Code	Modifier	Short Description	PA	Policy/Comments
92313		Contact lens fitting	No	If client enrolled in an MCO, bill the MCO. If client is enrolled in fee-for-service, bill through ProviderOne.
92314		Prescription of contact lens	No	Bill fee-for-service regardless of MCO enrollment.
92315		Rx cntact lens aphakia 1 eye	No	Bill fee-for-service regardless of MCO enrollment.
92316		Rx cntact lens aphakia 2 eye	No	Bill fee-for-service regardless of MCO enrollment.
92317		Rx corneoscleral cntact lens	No	Bill fee-for-service regardless of MCO enrollment.

Ocular Prosthesis

HCPCs Code	Modifier	Short Description	PA	Policy/Comments
L8610		Ocular implant	No	Available for clients age 21 and older. See the Outpatient Hospital Fee Schedules.

Washington State Health Care Authority

Authorization

See HCA's current ProviderOne Billing and Resource Guide for more information on requesting authorization.

What are the general guidelines for authorization?

- HCA 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.
- Note that authorization requirements are not a denial of service.
- When a service requires authorization, the provider must properly request authorization under HCA's rules and billing guides.
- When the provider does not properly request authorization, HCA returns the request to the provider for proper completion and resubmission. HCA does not consider the returned request to be a denial of service.
- Upon request, a provider must provide documentation to HCA showing how the client's condition met the criteria for prior authorization (PA) or expedited prior authorization (EPA).
- HCA's authorization of a service does not necessarily guarantee payment.

What is prior authorization (PA)?

- PA is a form of authorization used by the provider to obtain HCA's written approval for specific vision services, including hardware. HCA's approval is based on medical necessity and must be received before the service is provided to clients as a precondition for payment.
- HCA does **not** require PA for covered vision hardware that meet the clinical criteria found in the coverage section of this guide.
- HCA requires PA for covered vision hardware when the clinical criteria found in coverage section of this guide 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 request to HCA (see Authorization). HCA 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 if my request exceeds the limitations in this billing guide?

If a request exceeds the limitations in this billing guide, providers must submit limitation extension (LE) must be submitted to HCA following the authorization process. HCA 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. **Example**: Eyeglasses are not covered under the Family Planning Only Program.

How do I request a limitation extension?

To request a limitation extension (LE), providers may submit a request through direct data entry into ProviderOne (See HCA's Prior Authorization webpage) or by submitting the request in writing on:

- A completed *General Information for Authorization* form, HCA 13-835. See Where can I download HCA forms? and HCA's ProviderOne Billing and Resource Guide for more information.
- Complete the *Vision Care Authorization Request* form, HCA 13-739. This form is required for any vision hardware authorization request.

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

Fax all forms and documentation to 866-668-1214 (see Resources Available).

Download the *Vision Care Authorization Request* form, HCA 13-739, AND *General Information for Authorization* form, HCA 13-835. Fax both forms to HCA with the *General Information for Authorization* form as your cover letter.

What does the EPA process do?

The EPA process allows providers to apply HCA's clinical criteria and certify medical necessity. HCA establishes clinical criteria and identifies the criteria with specific codes. Providers then identify the EPA number that meets the clinical criteria for the services requested and bills HCA with that EPA number.

To bill HCA 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
- HCA 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.
- HCA may recoup any payment made to a provider if HCA later determines that the service was not properly authorized or did not meet the EPA criteria. Refer to WAC 182-502-0100 and WAC 182-544-0560.
- 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 HCA and HCA'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 contributes to broken eyeglass frames • Lost or broken glasses

Frame type	EPA Code	Criteria
Flexible frames	870000620	When the provider documents one of the following in the client's record: • The client has a diagnosed medical condition that contributes to broken eyeglass frames. • Reasons that the standard CI Optical frame is not suitable for the client. (e.g., client ages five or younger) • Lost or broken glasses

Replacement Eyeglass Lenses

Reason for replacement/lens 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. • Lost or broken lenses

Reason for replacement/lens 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 HCA's current Physician-Related Services/Healthcare Professional Services Billing Guide, to locate EPA numbers for blepharoplasties and strabismus surgery.

Washington State Health Care Authority

Ordering Vision Hardware

Who is HCA's vision hardware eyeglass contractor?

HCA'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. HCA does not pay any other optical manufacturer or provider for frames, lenses, or contact lenses.

> **Note**: CI Optical cannot provide client eligibility or benefit information. It is the provider's responsibility to verify eligibility before submitting an order to CI Optical.

Mail, fax, or email completed prescriptions and purchase orders for sample kits, eyeglass frames, eyeglass lenses, and contact lenses to:

1. Mail to CI Optical at 11919 West Sprague Avenue or PO Box 1959, Airway Heights, WA 99001-1959
2. Fax to 888-606-7789.
3. Email to ciopticalcustomercare@doc1.wa.gov.

CI Optical customer service phone number is 888-606-7788.

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 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 HCA has already purchased a pair of lenses or complete frames or contact lenses within the applicable benefit period (12 or 24 months, as appropriate).
- HCA requires CI Optical to process prescriptions within 15 working days, including shipping and handling time, after receipt of a **properly** completed order. HCA 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 HCA at 800-562-3022.
- CI Optical ships the eyeglasses to the provider.
- CI Optical bills HCA 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 HCA's designated supplier.

Washington State Health Care Authority

Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see Paperless Billing at HCA. For providers approved to bill paper claims, see HCA's Paper Claim Billing Resource.

What are the general billing requirements?

Providers must follow HCA's ProviderOne Billing and Resource Guide. These billing requirements include:

- Time limits for submitting and resubmitting claims and adjustments
- What fee to bill HCA 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

HCA 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 HCA'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

HCA 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.

HCA 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 HCA.

- Billing: Since payment for the surgical procedure codes with modifier 55 is a one-time payment covering the postoperative period, HCA 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 HCA 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 HCA.

Refer to HCA'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 HCA's **Billers and Providers** webpage, 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)** webpage.

Washington State Health Care Authority

Payment

How much does HCA pay for vision care?

HCA pays 100% of HCA contract price for covered eyeglass frames, lenses, and contact lenses when these items are obtained through HCA's approved contractor. For more information, see **Ordering Vision Hardware**.

To receive payment, vision care providers must bill HCA according to the conditions of payment found in this billing guide. See Billing for more information.