

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-1991

In the case of

Claim for

S.W.

(Appellant)

Medicare Advantage (MA)

(Part C)

(Enrollee)

(HIC Number)

United Healthcare/Secure
Horizons AARP Medicare
Complete

(MA Organization (MAO)/MA
Plan)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated June 20, 2011. The ALJ upheld the MA plan's denial of the enrollee's request for reimbursement for progressive and transition lenses, purchased at Catalina Optical, on September 7, 2010. The appellant-enrollee has asked the Medicare Appeals Council to review the ALJ's decision.

The regulation codified at 42 C.F.R. § 422.608 states that "[t]he regulations under part 405 of this chapter regarding MAC [Medicare Appeals Council] review apply to matters addressed by this subpart to the extent that they are appropriate." The regulations "under part 405" include the appeal procedures found at 42 C.F.R. part 405, subpart I. With respect to Medicare "fee-for-service" appeals, the subpart I procedures pertain primarily to claims subject to the Medicare, Medicaid and SCHIP Benefits Act of 2000 (BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). 70 Fed. Reg. 11420, 11421-11426 (March 8, 2005). The Council has determined, until there is amendment of 42 C.F.R. part 422 or clarification by the Centers for Medicare & Medicaid Services (CMS), that it is "appropriate" to apply, with certain exceptions, the legal provisions and principles codified in 42 C.F.R. part 405, subpart I, to this case.

The Council reviews the ALJ's decision *de novo*. 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's action to the exceptions raised by the party in the request for review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c).

The enrollee's timely-filed request for review, which included attachments, is admitted into the administrative record as Exh. MAC-1. The Council provided the MA plan a copy of the enrollee's request for review. The plan has not filed exceptions to the enrollee's request.

For the reasons set forth below, the Council adopts the ALJ's decision.

DISCUSSION

The enrollee, whose medical history includes cataract surgery (left eye) in July 2010, purchased progressive and transition lenses (V2781, V2744) at Catalina Optical on September 7, 2010. See, e.g., Exh. 4 at 1-3. She asks the Council to review the ALJ's unfavorable decision, issued June 20, 2011, which upheld the MA plan's denial of reimbursement for the cost of the lenses. The MA plan denied reimbursement on the basis that the lenses in question are not covered under traditional Medicare Part B coverage guidelines. Exh. 3 at 1. The independent review entity (IRE) agreed, on the same rationale. Exh. 5 at 2-3.

In sum, the ALJ determined that the MA plan may not be required to reimburse the enrollee for the lenses because "they are not Medicare covered items." Dec. at 6. In reaching this conclusion, the ALJ considered section 1862(a)(7) of the Social Security Act (Act), as well as a Durable Medical Equipment Medicare Administrative Contractor (DME MAC)'s policy article A23900. Dec. at 4-6. The ALJ explained,

Generally [MA] plans must provide coverage of all services that are covered by original Medicare. Section 1862(a)(7) of the Act specifically excludes eyeglasses from coverage under Medicare with the exception of 'one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens.'

Id. at 6.

Before the Council, the enrollee refers to, and quotes from, specific sections of the ALJ's decision, and concedes that the "tint/photo chromatic coating" and the "extra charge for the progressive lens" are "not covered." Exh. MAC-1 at 2. She argues, however, that "extra charge/difference" between progressive and standard lenses should be "separated out" such that the plan should be held responsible for paying for the standard lenses. *Id.* This argument, in essence, is the same argument raised during earlier levels of review. See, e.g., Exh. 1 at 26.

A MAO offering a MA plan must provide enrollees with "basic benefits," which are all items and services covered by Medicare Parts A and B available to enrollees residing in the plan's service area. 42 C.F.R. § 422.101(a). A MA plan must comply with national coverage determinations, local coverage determinations, and general coverage guidelines included in original Medicare manuals and instructions. 42 C.F.R. § 422.101(b). The plan must inform the enrollee of applicable conditions and limitations, premiums and cost-sharing (such as copayments, deductibles, and coinsurance) and any other conditions associated with the receipt or use of benefits. 42 C.F.R. § 422.111(b)(2). Therefore, for the lenses at issue to be covered by Medicare, they must either be covered under Medicare Part B or covered under the enrollee's plan.

Medicare is a defined-benefits program. Excluded from Medicare B coverage are many items and services including, but not limited to, procedures performed to determine the refractive state of the eye, and eyeglasses and corrective lenses, even if they are determined to be medically reasonable and necessary for Medicare beneficiaries. See Act, section 1862(a)(7). In general, eyeglasses and contact lenses are not covered, with limited exceptions, one of which is that Medicare may cover a pair of conventional eyeglasses or conventional contact lenses furnished after cataract surgery during which an intraocular lens is inserted. See Act, § 1861(s)(8); 42 C.F.R. § 411.15(b).

The relevant section of the plan's 2010 Evidence of Coverage (EOC) is substantially similar to the language in section 1861(s)(8) of the Act. The EOC provides, in part:

Vision Care

Covered services include:

One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.

Exh. 2 at 57. The EOC further provides that there is a "\$0" copayment "for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery." *Id.*

The plan covers lenses in accordance with traditional Medicare Part B coverage guidelines, which, as the ALJ and the IRE explained, for the purposes of the instant case, allow for coverage of *standard* lenses after cataract surgery. They do not allow for coverage of upgraded lenses, such as photochromatic or progressive lenses, or lenses with special add-on features like tinting.

The ALJ's decision concluding that the plan may not be required to reimburse the enrollee for the progressive and transition lenses purchased on September 7, 2010, was legally sound. The enrollee's contentions provide no cause for changing the ALJ's decision.

The Council adopts the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

Date: October 6, 2011