Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In re CMS LCD Complaint: Low Vision Aids (V2600-V2615)	Date: May 31, 2007 Docket No. C-06-705 Decision No. CR1603

DECISION

An aggrieved Medicare beneficiary (Aggrieved Party or AP) challenges portions of the Local Coverage Determination (LCD) for Refractive Lenses (L51) issued by the Medicare Contractor, Noridian Administrative Services (Contractor). For the reasons discussed below, I find the LCD to be reasonable.

Background

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program (Social Security Act (Act), §§ 1102, 1871, 1874), and contracts with carriers and intermediaries (Medicare contractors) to act on its behalf in determining and making payments to providers and suppliers of Medicare items and services. Act, §§ 1816, 1842. To this end, Medicare contractors issue written determinations, called LCDs, addressing whether, on a contractor-wide basis, a particular item or service is covered. Act, § 1869(f)(2)(B). A Medicare beneficiary who has been denied coverage for an item or service based on an LCD may challenge that LCD before an administrative law judge (ALJ). In reviewing that challenge, the ALJ is instructed to defer to the "reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law" by CMS and its contractors. Act, § 1869(f)(2)(A)(i)(III); 42 C.F.R. § 426.110.

In this case, the Aggrieved Party suffers significant vision loss caused by severe "degenerative myopia." AP Ex. 7. His vision is failing, and his physician has recommended for him an electronic magnifier. That device magnifies images up to 50 times their size and projects them on to a television screen, making it possible for even those with severe visual impairments to read or perform near point work tasks. AP Exs. 1, 8. In a March 6, 2006 letter, his physician requested reimbursement for this magnifier. AP Ex. 1. However, in correspondence dated April 4, 2006, and a remittance notice dated

June 5, 2006, the Contractor denied Medicare reimbursement for this device. AP Exs. 2, 3. The April 4, 2006 letter cites a Medicare policy for Refractive Lenses, which sets forth coverage and payment rules for refractive lenses and related items, including low vision aids.

In support of his claim, the Aggrieved Party has submitted a statement, accompanied by eight exhibits (AP Exs. 1-8). The Contractor has submitted its LCD record (Contractor Ex. 1) and a letter dated April 30, 2007.[1] I receive the exhibits into the record.

Discussion

A Medicare contractor could reasonably conclude that "low vision aids" fall within the eyeglasses exclusion of the Act.[2]

The LCD in question provides, in pertinent part, that

> Low vision aids (V2600-V2615)[3] will be denied as noncovered because coverage under the Medicare prosthetic benefit is limited to persons with congenital absence or surgical removal of the lens of the eye.

Contractor Ex. 1, at 3. The Contractor's position here is straight-forward: it takes its marching orders from CMS, and CMS has long interpreted the Act's eyeglass exclusion to preclude payment for low-vision aids.

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[1] The AP objects to the untimeliness of the Contractor's submission. I share the AP's distress at the unexplained tardiness of that document. However, too much is at stake in these LCD challenges for them to turn on a contractor's dereliction. In any event, the Contractor's submission simply refers to public documents which, under any circumstances, I would have been bound to consider.

[2] I make this one finding of fact/conclusion of law to support my decision.

[3] Providers and suppliers submit their claims for reimbursement, identifying the service or item by codes, which are found in the Healthcare Common Procedure Coding System (HCPCS) published by the American Medical Association. The codes referred to in L51 include: hand-held low vision aids and other nonspectacle mounted aids (V2600), single lens spectacle mounted low vision aids (V2610), and telescopic and other compound lens systems, including distance vision telescopes and compound microscopic lens systems. Contractor Ex. 1, at 14.

With limited exception, the Medicare statute specifically precludes reimbursement for eyeglasses:

> No payment may be made . . . for any expenses incurred for items or services . . . where such expenses are for . . . eyeglasses (other than eyeware described in section 1861(s)(8)) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes . . . .

Act, § 1862(a)(7). The exception, found at section 1861(s)(8), provides Medicare coverage for eyeglasses if they are "prosthetic devices," that is, they "replace all or part of an internal body organ . . . including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens."

The Secretary of Health and Human Services (Secretary) has the discretion to interpret the statute and to assign a product to a particular Medicare category even when this will result in non-coverage determinations by Medicare. Here, acknowledging that the statute is ambiguous, CMS proposes a regulatory change

> to clarify that the scope of the eyeglass coverage exclusion encompasses all devices irrespective of their size, form, or technological features that use one or more lens to aid vision or provide magnification of images for impaired vision.

Medicare Program; Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Other Issues, 71 Fed. Reg. 25,654, 25,687 (proposed May 1, 2006). If the proposed rule were final, my inquiry would stop, since I am bound by the Secretary's regulations. 42 C.F.R. § 426.405(d)(13). Since the rule is not yet final, I review CMS's underlying justification for the longstanding policy/proposed rule.

In CMS's view, the statute does not support a narrower interpretation – one that would limit the term "eyeglasses" to those lenses supported by frames that pass around the nose and ears. First, pointing to the medical definition of "eyeglass" as a "lens for aiding sight," (Dorland's Illustrated Medical Dictionary (28th ed. 1994)), CMS includes, within the definition of "eyeglasses," those items that share their underlying technology and function, i.e., that use lenses to assist persons with impaired vision.

Second, CMS points out that if the term "eyeglasses" refers only to lenses supported by frames that pass around the nose and ears, then the eyeglass exclusion would not apply to contact lenses. But if contact lenses were not included, Congress would have had no reason to except from the section 1862(a)(7) exclusion contact lenses after cataract surgery. Comparing section 1862(a) with section 1861(s) shows that the eyeglass exclusion also applies to contact lenses, except for one pair after cataract surgery. That the eyeglass exclusion plainly applies to contact lenses "reinforces the interpretation that the use of lenses to aid impaired vision is the scope of what is excluded by the eyeglass exclusion, and not just lenses supported by frames that pass around the nose and ears." 71 Fed. Reg. 25,687.

Next, CMS observes that the statute's reference to "conventional eyeglasses" in section 1861(s)(8) affirms that the term "eyeglasses" has a wider application than "conventional eyeglasses." The terms "conventional eyeglasses" and "eyeglasses" are not synonymous in the statute. 71 Fed. Reg. 25,687.

CMS notes that its broad interpretation of "eyeglasses" is consistent with regulatory language used for the optional eyeglass benefit in the Medicaid program under 42 C.F.R. § 440.120(d), which defines eyeglasses as "lenses, including frames and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist." The Medicaid provision gives states flexibility to adopt a reasonable definition that includes low vision aids that are determined to be medically necessary.

> Consistent with this framework, we consider the eyeglass exclusion for the Medicare program to apply to eyepieces, hand-held magnifying glasses, contact lenses and other instruments, such as closed-circuit televisions and video magnifiers that use lenses to aid vision.

71 Fed. Reg. 25,654, 25,687.

Finally, CMS recognizes that the technology of using lenses to aid low vision may be improved with new innovations, such as contact lenses, progressive lenses, and low vision aids, but reasons that

> this does not exempt the new technology from the eyeglass exclusion. The adaptation of the vision aid technology does not change the essential nature of the device: a video magnifier is still a device that utilizes a lens to enhance vision.

71 Fed. Reg. 25,654, 25,687; *Accord, Warder v. Shalala*, 149 F.3d 73 (1st Cir. 1998) (where the First Circuit affirmed the Secretary's classification of a technologically advanced seating system as durable medical equipment (DME), not an orthotic, because the system's functions included the same functions as a wheelchair).

Conclusion

Based on these analyses, I find reasonable CMS's interpretation of the statute. Because the Contractor's LCD for Refractive Lenses (L51) reflects CMS's reasonable interpretation of the statute, I find it valid under the reasonableness standard.

/s/
Carolyn Cozad Hughes
Administrative Law Judge