

STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 16,977
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Appeal of)

INTRODUCTION

The petitioner appeals a decision of PATH declining to reimburse her under the Medicaid program for out-of-pocket payments for contact lenses. The issues are whether this matter has already been decided by the Board and whether the petitioner can obtain reimbursement for out-of-pocket expenses.

FINDINGS OF FACT

1. On October 12, 2000, PATH gave prior approval to the petitioner, a seventeen-year-old girl, for the purchase of gas permeable contact lenses. However, when the petitioner tried to obtain these specialized lenses through her local Medicaid providers she was turned down because the reimbursement rate was too low. The petitioner's guardian identified an inexpensive non-Medicaid provider of the lenses and purchased them privately, spending \$180 on October 19, 2000.

2. The petitioner's guardian filed an appeal dated November 1, 2000 informing PATH that she had been unable to

find a local Medicaid provider who would agree to sell her the lens for the Medicaid reimbursement cost and that she had obtained the lenses on her own through a non-Medicaid provider. She further informed PATH that the petitioner had lost a lens four days later and had to buy a new one and that it was likely she would need to frequently replace the lenses. She asked for reimbursement of her "loss" and for future coverage adding that both she and the petitioner were on Social Security and could not afford to buy the lenses themselves.

3. The appeal was received by the Board on November 8, 2000 and set for hearing on December 14, 2000. In the meantime, the petitioner's guardian purchased more lenses, paying \$90 on November 3, 2000, \$90 on November 21, 2000 and \$90 on December 12, 2000.

4. At some point after the appeal was filed, the petitioner's guardian obtained the assistance of a legal aid attorney. She says she did this at the suggestion of PATH. Documents provided by the petitioner showed that her attorney contacted PATH's attorney on December 13, 2000 and was assured that the full cost of the contact lenses would be reimbursed to her Medicaid providers but that the Department would not reimburse any out-of-pocket expenses she had incurred by going

to non-Medicaid providers. The petitioner's attorney advised the petitioner that she could contest the refusal to reimburse but that she did not think there was a legal basis for this.

5. On December 14, 2000, the petitioner's attorney notified the Board in writing that she was withdrawing the appeal on behalf of the petitioner. The withdrawal was based on PATH's representation that Medicaid would cover the entire cost of the lenses in the future if they were purchased through a Medicaid-provider.

6. Subsequent to the conclusion of this appeal, Medicaid paid for surgically implanted INTACS for the petitioner, making contact lens use unnecessary.

7. On March 1, 2001, the petitioner's guardian read a news article regarding a United States Supreme Court decision which said that Congress had violated the First Amendment to the Constitution when it placed restrictions on the ability of legal services programs to challenge the validity of welfare laws and regulations in court. The petitioner interpreted this article as meaning that she could now bring up issues that her attorney had been unwilling or unable to bring up during the prior appeal. She now seeks reimbursement from PATH for all of her out-of-pocket expenses for lenses pursuant to a new appeal filed on March 2, 2001.

ORDER

The matter shall not be dismissed as res judicata. The decision of the Department denying reimbursement of the petitioner's out-of-pocket expenses is affirmed.

REASONS

This matter was never decided by the Board. Therefore, it cannot be said that the matter is res judicata. It appears to be true that the petitioner's attorney withdrew her original appeal for payment of out-of-pocket expenses. However, there was nothing in the withdrawal that indicated that the petitioner was waiving her right to raise the issue again in a timely fashion. As long as the Board has not issued a decision on the matter before, there is nothing that would prevent the petitioner from re-filing an appeal as long as it is within the 90-day period for appealing PATH decisions. See Fair Hearing Rule No. 1. Since PATH never sent the petitioner a formal letter of denial with regard to her request for reimbursement of past expenses, it is difficult to fix a date on which her grievance arose. However, it is fair to say that she knew through the letter to her attorney dated December 13, 2000 that the Department would

not reimburse her past out-of-pocket expenses. Her second appeal on March 2, 2001, was within ninety-days of the prior denial. Her appeal must be considered timely and properly before the Board.

Out-of-pocket expenses can be reimbursed under the regulations only if an application for benefits was made, denied and later granted as a result of a review. See M152. The petitioner in this matter was not denied benefits. She received authorization for the benefits and then was unable to obtain the benefit through a local provider. There was no evidence offered that the petitioner asked the Department for the name of another Medicaid provider who could supply the lenses. Instead, she bought the lenses through a non-Medicaid provider and filed an appeal. After filing the appeal, the Department contracted with some other providers to supply these services and guaranteed a reimbursement rate which would induce her local provider to supply the lenses.

If there was no Medicaid provider in the state that would supply these lenses, the petitioner may have had an argument that she was in effect denied coverage for the lenses. No evidence supporting such a contention was produced at the hearing. It must be concluded, therefore, that the petitioner was not denied coverage of any benefits by the Department.

Without meeting that criterion, the petitioner cannot be reimbursed for payments she made to non-Medicaid providers for the services. The petitioner should have asked the Department for names of Medicaid providers who would assist her before resorting to using non-Medicaid providers. The decision of the Department not to reimburse her for these services is upheld. To reiterate, the petitioner's appeal is not dismissed. However, it is concluded that the petitioner is not entitled to reimbursement based on the facts presented and the applicable regulations.

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