

STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 19,108
)
Appeal of)

INTRODUCTION

The petitioner appeals a decision of the Department for Children and Families (DCF) denying coverage for specialized contact lenses.

FINDINGS OF FACT

1. The petitioner is a Vermont Health Access Program (VHAP) Managed Care recipient who has a condition called keratoconus which causes thinning and distortion of her corneas with a resulting distortion of her vision. The petitioner works as a companion to an older woman. She has trouble reading even large font books and cannot drive at night.

2. The petitioner's condition was treated with corrective lenses until recently when her vision deteriorated to the point where lenses held away from the eye were no longer correcting the condition. Her ophthalmologist prescribed a stronger specialized contact lens that has a rigid gas permeable center surrounded by a soft lens that

helps to stabilize the lens on her eye. Without this stabilization, the petitioner's ability to function visually is severely compromised.

3. The petitioner applied for coverage of these lenses through the VHAP Managed Care program. She was denied coverage on May 21, 2004 because contact lenses are "not a covered service."

4. The only other option available to the petitioner to correct this condition is corneal transplantation. This is a procedure typically reserved for advanced cases where functional vision cannot be attained with contacts.

5. The petitioner has provided ample documentation that these lenses are medically necessary for her to restore her vision to close to normal functioning and are not merely cosmetic or for the sake of convenience.

ORDER

The decision of DCF is affirmed.

REASONS

The VHAP Managed Care program was adopted in 1995 to expand access to health care benefits to low-income Vermonters who cannot meet categorical and financial eligibility requirements for Medicaid. VHAP 4000. Early in the history

of the program, eyewear was furnished to recipients through a "sole source contractor." VHAP 4003.1(c). As a cost cutting measure, the coverage of "all eyewear was suspended indefinitely" by a regulation enacted in July of 2003 and re-enacted in December of 2003. VHAP 4003.1(c). Procedures accompanying these regulations state that there is no longer any coverage of "eyeglasses and contact lenses" and that "eyewear, including but not limited to eyeglasses and contact lenses" are completely excluded from coverage. P-4005(A) and (B)(3)(e). While eyeglasses and contact lenses may indisputably be medically necessary for countless beneficiaries, DCF requires recipients to cover the costs of those items themselves.

The petitioner is asking for a "special contact lens" to correct her vision problems. While the type of contact lens she needs may not be of the usual variety, it clearly is "eyewear" intended to improve vision and as such falls squarely within the proscription found in the above regulation and procedures. The petitioner points out that VHAP would probably cover the cost of corneal transplants if she opted for such surgery. She argues, therefore, that DCF should be ordered to provide her with the less expensive and intrusive correction for her vision provided by contact lenses. While

this might be a sensible approach, the petitioner does not point out any regulation which would require DCF to take such an action.¹

The petitioner was invited to put forth any arguments that she might wish to make that the general prohibition against payment for eyeglasses and contact lenses violated the federal regulations governing the VHAP program. She offered no such argument. It must be concluded, therefore, that DCF has acted legally when it eliminated payment for eyeglasses and contact lenses from its program. As DCF has denied coverage of these lenses under its validly adopted regulation, the Board is constrained to uphold this decision. 3 V.S.A. § 3091(d), Fair Hearing Rule 17.

#

¹ Unlike the Medicaid program, the VHAP program does not have any procedure for requesting exceptions to the rules. See M108. This undoubtedly reflects the fact that persons eligible for the Medicaid program are so impoverished that denial of coverage for any medical item or service means that beneficiaries would have to go without that item or service.