BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of:	)	
	)	
V. C.	)	OAH No. 09-0553-PER
	)	Agency No. 2009-0803

DECISION

I. Introduction

V. C. submitted a claim for benefits under her health care plan for the cost of a presbyopia-correcting intraocular lens. The claim was denied on the ground that the lens implanted was more costly than a standard lens implant. Ms. C. exhausted her administrative appeals, and the denial was upheld by the administrator. Ms. C. appeals.

Ms. C. has received payment under the health plan's medical benefit for the cost of cataract surgery and implantation of a standard intraocular lens. She is not entitled, under the medical benefit, to coverage for the additional cost to implant a presbyopia-correcting intraocular lens, which is not medically necessary for the treatment of cataracts or for the treatment of presbyopia. Ms. C. has also received payment from the health care plan for the cost of a standard intraocular lens. She has not shown that she is entitled, under the either the medical benefit or the vision benefit, to coverage for the additional cost of a presbyopia-correcting interocular lens. Accordingly, Ms. C.'s claim for payment of the additional cost of a presbyopia-correcting intraocular lens is denied.

II. Facts

V. C. is a retired employee in the Public Employees' Retirement System. As such, she is entitled to health care benefits under the retiree health care plan. Prior to 2007, V. C. had a vision condition known as presbyopia:

> Presbyopia, a type of refractive error, is an age-associated progressive loss of the focusing power of the lens of the eye resulting in difficulty seeing objects at near distance, or close-up. Presbyopia occurs as the natural lens of the eye becomes thicker and less flexible with age.[1]

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1 Centers for Medicare & Medicaid Services, Ruling No. 05-01 (May 3, 2005).

In early 2007, Ms. C. began experiencing a loss of vision. The condition worsened over time and made it difficult for her to read fine print or drive at night.[2] On December 6, 2007, Ms. C. contacted her health plan servicer, Premera, and inquired about coverage for lenses in connection with cataract surgery, and was not informed of any specific restrictions.[3] On January 14, 2008, she was examined by Dr. Bruce Ballon, who diagnosed nuclear sclerosis (commonly known as a cataract) in the left eye.[4] Dr. Ballon scheduled Ms. C. for cataract surgery on her left eye.[5] In cataract surgery, the eye's natural lens is replaced with an artificial lens. Dr. Ballon offered Ms. C. the choice between two lenses for the implant: a standard intraocular lens (which would not correct her pre-existing presbyopia) or a presbyopia-correcting intraocular lens.[6] On Dr. Ballon's recommendation, Ms. C. elected to have the presbyopia-correcting lens.[7]

The surgery was performed by Dr. Ballon at the Harman Eye Clinic. On the date of her surgery, Ms. C. was informed by the Harman Eye Clinic that the additional cost of a presbyopia-correcting intraocular lens and the services necessary to implant it (including after care) was not covered by Medicare, and that she would be responsible for those increased costs.[8] The cost of the non-covered services was estimated as $2,700.[9] Ms. C. paid the estimated cost of the non-covered services to the Harman Eye Clinic in advance, and the cataract surgery was performed on February 19, 2008.

After the surgery, staff of the Harman Eye Clinic contacted Premera and asked what benefits were payable. The clinic's staff was informed that the cataract surgery was 100% payable as an outpatient procedure under a diagnostic code for cataract nuclear sclerosis (ICD 366.16) with the procedure code for a standard cataract removal and insertion of an intraocular

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2 Chart Note, p. 2 (1/14/08).

3 Ms. C. asserts that before she scheduled the cataract surgery, she was "assured [by Premera] that…there were no restrictions as to the type of lens." Letter, V. C. (11/25/2008), p. 1. According to Premera's notes, Ms. C. had been told that lens reimbursement "would be based on the allowed amount". R. 45. Premera has no record of any contact with Ms. C. regarding this issue prior to her surgery other than a telephone call on December 6, 2007. Premera's log notes for that call state that Ms. C. inquired "to see what contact lenses were not covered following cataract surgery" and that she was told "that there is no available list that would advise what lenses are and are not covered." R. 40. It is possible that there was some miscommunication or misunderstanding during this conversation. Ms. C. has not proven that she was informed by Premera, prior to the surgery, that the there was no restrictions on coverage for lens implants in connection with cataract surgery. The preponderance of the evidence, however, is that she called, she asked about lenses and that she was not informed of any specific restrictions.

4 Letter, B. Ballon (2/18/10); Chart Note, p. 4 (1/14/08); Operative Report (2/19/08).

5 *Id.*

6 *Id. See* Chart Note, p. 4 (1/14/08). Dr. Ballon did not recommend a mutifocal intraocular lens, due to a previous Branch Retinal Vein Occlusion. *Id.*

7 R. 66.

8 R. 59.

9 R. 59.

lens (CPT 66984).[10] The clinic provided Ms. C. with a bill showing a bundled fee of $2,540.00 for the procedure, including the implanted lens, under the diagnostic code for cataract nuclear sclerosis (ICD-9 366.16),[11] with the procedure code for a standard cataract removal and insertion of an intraocular lens (CPT 66984).[12] The billing shows that the bundled fee consists of an insured cost of $1,053.53 and "Medicare savings" of $1,486.47.[13]

The eye clinic, Dr. Ballon, and Dr. Drew Scheele submitted claims to the health care plan under the plan's medical benefit in connection with the cataract surgery. The clinic's claim (No. 800000005900)[14] in the amount of $2,540 was more than twice the recognized facility charge[15] for cataract surgery ($1,038.03); of the amount charged, Medicare paid $827.32, and the health care plan paid $210.71.[16] Ms. C. was deemed responsible for the entire remaining amount of the clinic's bill, or $1,501.97.[17] Dr. Ballon's claim (No. 800000005900)[18] in the amount of $1,970 was more than twice the recognized physician's fee for cataract surgery ($947.10);[19] of the amount charged, Medicaid paid $823.89, and the health care plan paid $123.21.[20] Ms. C. was deemed responsible for the entire remaining amount of Dr. Ballon's bill, or $1,022.90.[21] Finally, Dr. Scheele's claim (No. 800000003600)[22] in the amount of $562.36 was paid in the amount of $32.42. Thus, the total amount claimed under the medical benefit for the cataract surgery and implant was $5,072.36, and the total amount paid by Medicare and the health care plan was $2,017.65 (plus the amount paid by Medicare for Dr. Sheele's services); Ms. C. was deemed liable for $2,524.87 (plus whatever Medicare did not pay for Dr. Scheele's services).[23] That

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10 R. 41 (1/30/2008 lognote).

11 R. 82.

12 R. 82. The coding is listed as "CPT". CPT is the acronym for the American Medical Association's Current Procedural Terminology, used as basis for the federally-mandated Healthcare Common Procedure Coding System (HCPCS) for purposes of Medicare and Medicaid. A list of codes with descriptions may be accessed at www.coderscentral.com.

13 R. 82.

14 R. 76C.

15 The recognized charge is the lowest of the provider's usual charge, the charge determined as appropriate in light of cost, or the charge determined on the basis of the usual cost (90th percentile) in the area. Health Care Plan, pp. 13-14.

16 R. 76C.

17 R. 76C.

18 R. 76B. This claim is also listed on the Claims Inquiry sheets submitted in connection with Claim No. 080000007800. *See* R. 85-90.

19 R. 76B.

20 R. 76B.

21 R. 76B.

22 R. 85.

23 One other claim was processed under the medical benefits provision. That claim, which is not referenced in the claims notes in the record, is Claim No. 08000000002800, in the amount of $1,053.53 for services provided

amount reflects the estimated $2,700 additional costs to implant the presbyopia-correcting lens that Ms. C. prepaid. Presumably, the eye clinic's and Dr. Ballon's charges were more than twice the recognized amount because their charges included the $2,700 in additional costs associated with that lens.[24]

Ms. C., who knew that the lens itself would not be covered by Medicare, contacted Premera to see about getting insurance benefits under her own health care plan for that expense. Because Ms. C.'s plan is supplemental to Medicare,[25] Premera informed Ms. C. that it could not process her claim for the lens until it had been submitted to Medicare.[26] Ms. C. explained that because Medicare would not cover a presbyopia-correcting intraocular lens, the eye clinic could not submit a claim for the lens to Medicare.[27] Ms. C. was advised to submit a claim directly to Premera with a letter of explanation.[28] As directed, Ms. C. submitted a claim for payment for the lens[29] on March 3, 2008, along with a letter of explanation and a copy of her receipt in the amount of $2,700 for her prepayment of the estimated additional cost of the surgery and the lens.[30]

Claim No. 080000007800 was apparently initiated by Ms. C.'s March 3 letter.[31] It was initially processed under the plan's vision benefit.[32] After receiving the claim, Premera informed

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by Harman Eye Clinic; it was initially paid in the amount of $947.10, but was later reimbursed. R. 74A, 76A. The amount of the claim is the precise amount of the insurable cost identified on the eye clinic's bill. R. 82. Presumably, this claim was submitted by the clinic as the portion of the total bill attributable to cataract surgery with implantation of a standard lens, and the amount paid was reimbursed because that cost had been paid under Claim No. 800000005900.

[24] Assuming the providers' claims as submitted to the health plan include the entire amount charged, including the $2,700 she prepaid, then the charge for the cataract surgery and implantation of a standard intraocular lens was $2,372.36 ($5,072.36 - $2,700). That is substantially equivalent to what Medicare and the health care plan paid ($2,181.15, plus a portion of Dr. Scheele's bill), and would explain why the amount charged by the eye clinic and Dr. Ballon was approximately twice the recognized charge for a standard implant. A June 2005 article in "Cataract and Refractive Surgery Today" includes a demonstrative table suggesting that implanting a presbyopia-correcting lens (exclusive of the lens) would increase the typical cost of the procedure (*i.e.*, the cost of cataract surgery with implantation of a standard intraocular lens) at a physician's office by $1,400, from $900 to $2,300. *Id.*, Table 1 (p. 37).

[25] Health Care Plan, p. 17.

[26] R. 41 (3/3/2008).

[27] R. 41 (3/3/2008).

[28] R. 41 (3/3/2008).

[29] Premera's notes state that "originally the claim was submitted under the vision hardware benefit." R. 46. Mr. C.'s letter specifically identifies the lens as the item for which she sought payment. The claim for she filled out with the letter includes "implant" under the vision benefit, and "cataract removal" under the medical ("all other") benefit. The claim by Ms. C. clearly indicates that the amount of $2,700 includes the additional cost of the surgery, the implant, and the lens. R. 80.

[30] R. 78.

[31] Premera's claims inquiry notes track this claim sequentially through the various actions taken on it, under the claim numbers 08000007800-7804. R. 85-90.

Ms. C. that it needed more information.[33] Ms. C. called Premera to discuss the claim on May 7, 2008; Premera contacted the eye clinic and obtained additional information.[34] On May 24, 2008, based on a claim form showing a diagnosis of presbyopia (ICD 367.4) and provision of two specialty occupational multifocal lenses (V2786),[35] Premera issued an explanation of benefits (Claim No. 080000007800) showing a payment to the eye clinic of $2,160, or 80% of the claim, indicating that payment had been co-ordinated with the primary carrier (Medicare), and leaving a balance of $540 uncovered.[36] When the eye clinic received the payment, it noticed that the lens code (V2786) was incorrect, and it reimbursed the payment.[37] With the reimbursement, the eye clinic submitted a corrected claim (DCN 081000300646) showing a diagnosis of presbyopia (ICD 367.4) with the correct lens code (V2788) and the code modifier GY (used to indicate that the lens was not covered by Medicare).[38] That claim was sent for processing on June 25, 2008.[39] On July 12, Premera issued a second explanation of benefits showing that the reimbursement had been received (Claim No. 080000007801).[40] On July 31, Premera issued a third explanation of benefits (Claim No. 080000007802), this one denying the claim on the ground that the lens was not covered (based on the GY modifier).[41] The eye clinic submitted a second corrected claim (DCN 080000001052) changing the procedure diagnosis from presbyopia to cataract surgery

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[32] R. 43 (TC 7/21/2008 @ 10:32:23) ("V. was advised that we will reimburse her according to benefits under her vision plan."); R. 46 (TC 8/8/2008 @ 10:49:31 ("originally the claim was submitted under the vision hardware benefit"); R. 23 (letter, J. Hinderlie to Premera, May 11, 2009).

[33] See R. 42 (5/7/2008 TC @ 12:07:50) ("The member sent claim for cataract lens totaling $2700.00 but received a note back saying they needed information from Medicare who won't cover it.").

[34] R. 42 (TC 5/7/2008 @ 12:07:50); R. 100.

[35] R. 60, 85. The actual initial claims document is not in the record. According to a claims note dated July 28, the original claim is DCN 08100001313. R. 87. Since Ms. C.'s March 3 letter did not include any billing code, it appears that the eye clinic must have submitted a document of some sort to the eye clinic with an incorrect billing code it: V2786 instead of V2788.

[36] R. 75 (Claim No. 081000007800).

[37] R. 42 (6/20/2008 @ 9:08:04); R. 74B (July 12, 2008, EOB, showing recovery of $2,160 from the provider due to an overpayment).

[38] R. 91. DCN 08100000046 is an undated claim form (bearing the handwritten note "corrected claim") submitted by the eye clinic with a diagnosis of presbyopia. The claim was sent with the payment refund. *See* R. 44 (TC 7/30/2008 @ 14:51:22 ("The provider sent a refund with a corrected claim changing the CPT code to V2788GY…. The Customer Service Representative…confirmed that the refund was received and that the claim would now reprocess."). The V2788 code may be used "to indicate any additional charges that accrue when a [presbyopia-correcting lens] is inserted in lieu of a conventional [intraocular lens]." CMS Online Medicare Claims Processing Manual, Chapter 32, §120.1. The "GY" code means that the procedure (or item) is not covered by Medicare. R. 52 (TC 9/25/2008 @ 10:47:14).

[39] R. 42 (6/20/2008); R. 100.

[40] R. 74B; R. 85.

[41] R. 74 (July 31, 2008, EOB). A Premera customer service representative explained that "the way it is coded now is a non-covered service." R. 45 (8/5/2008 TC @ 10:21:16.

(ICD 366.16), with the same lens (V2788), still using the GY modifier.[42] The plan then issued a fourth explanation of benefits (Claim No. 081000007803), again showing that the claim had been denied on the ground that the procedure was not covered (again, based on the GY modifier).[43] The eye clinic then submitted a third corrected claim (DCN 08000000064), this one deleting the GY modifier.[44] On October 18, the health plan issued a fifth explanation of benefits (Claim No. 080000007804), again showing that the claim had been denied on the ground that the procedure was not covered.[45] Ms. C. appealed that decision on November 25, 2008,[46] and following three levels of review (two internal and one external), the health plan paid $150, the amount offered for a standard interocular lens,[47] on the ground that this was the least expensive alternative supply and that any additional payment was not medically necessary as required for payment under the medical benefit.[48]

III. Discussion

A. The Claim Is For the Additional Cost of a Presbyopia-Correcting Lens

It is undisputed that Ms. C. required cataract surgery, and that cataract surgery requires implantation of an intraocular lens. It is Medicare policy to pay for that portion of the cost of implanting a presbyopia-correcting lens during the course of cataract surgery that is equal to the cost of implanting a standard lens.[49] If the procedure is performed in an office setting, such as

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[42] R. 92-93. The corrected claim is undated, but it was submitted by August 19. R. 73A. Premera had advised Ms. C. on August 8 that the prior corrected claim (DCN 081000000646, with the diagnosis of presbyopia) had been denied because it fell within "an exclusion per page 54…of the benefit book under 'charges for or related to eye surgery mainly to correct refractive errors.'". R. 46 (TC 8/8/2008 @ 10:49:31). (Currently, this exclusion, which excludes eye refractions from coverage under the medical health provisions of the plan, is at page 57 of the health care plan.) *See also* R. 49 (8/19/2008) ("Virginia was advised that when the provide[r] got their EOP (Explanation of Payment) and saw the diagnosis that it processed with they submitted a corrected claim.").

[43] R. 73 (September 6, 2008, EOB).

[44] R. 94. The claim form is undated, as is the corrected claim cover sheet. R. 84A. It appears that the eye clinic submitted this corrected claim on September 15, following s series of telephone conversations among the parties. R. 51, 100H (TC 9/15/2008 @10:33:24. A handwritten note on the September 6 EOB states that on September 15, the eye clinic "supplied new claim 2 new CPT code."

[45] R. 72 (October 18, 2008, EOB).

[46] R. 64.

[47] R. 34 ("the least costly alternative would be V2630 or V2632"). Those are the codes for standard interocular lenses.

[48] R. 17-18, 32-33, 56-57.

[49] *See* Centers for Medicare & Medicaid Services, Ruling No. 05-01 (May 3, 2005). A similar rule was announced in 2007 for astigmatism-correcting implants. Centers for Medicare & Medicaid Services, Ruling No. 1536-R (January 22, 2007).

the eye clinic,[50] Medicare considers the cost of a standard intraocular lens to be built into the facility's charge unless the lens is billed separately, in which case Medicare will make a separate payment for a standard intraocular lens.[51] Similarly, Premera will pay for the cost of cataract surgery under the medical benefit, including the cost of implanting a standard intraocular lens, as it has in connection with Ms. C.'s cataract surgery, but it will not pay for any additional costs attributable to implanting a presbyopia-correcting lens; Premera generally considers the cost of the intraocular lens to be built into the facility charge,[52] but in this case, upon review, it paid the recognized cost of a standard intraocular lens even though no separate billing was submitted for an intraocular lens.

The total charge for the cataract surgery and implantation of a presbyopia-correcting lens was $5,072.36. Ms. C. has received the full benefit payable under Medicare and the health care plan for the cost of cataract surgery and a standard intraocular lens, in this case $2,017.65 (plus whatever Medicaid paid for Dr. Scheele's services). Ms. C. has paid $2,700 out of pocket, which was the estimated total additional cost of the presbyopia correcting lens (surgery, after care and lens).

The claim that is at issue in this case does not include the additional cost of the surgery or any after care. Rather, as described by Ms. C. in her letter of March 3, 2008, the claim was for the additional cost of a presbyopia-correcting intraocular lens, exclusive of the cost of surgery and after care. The claim was initially considered and denied by Premera under the plan's vision benefit on the ground that the item was not covered under the vision plan. However, on appeal the claim was considered under the plan's medical benefit and was denied on the ground that a

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[50] Medicare billing procedures are detailed in the CMS Online Medicare Claims Manual (hereinafter, "Claims Manual"), available at www.cms.gov/Manuals/IOM (accessed May 4, 2010). The POS (Place of Service) identified on the claims forms is an office (Item 24B; POS code 11). *See* Claims Manual, Ch. 26, §10.5.

[51] The provisions applicable to cataract surgery and implantation of a presbyopia-correcting lens are detailed in the Claims Manual, Ch. 32, §120. Billing procedures vary, depending on whether the procedure is performed in an office or in hospital or ambulatory surgical center, but in all cases the procedure is billed as if a conventional lens had been implanted. *Id.* When the procedure is performed in a hospital or ambulatory surgical center, the facility is directed to "report HCPCS code V2788 to indicate any additional charges that accrue for insertion of a [presbyopia-correcting intraocular lens]." *Id.* Medicare does not pay separately for the cost of the lens itself when inserted at a hospital or ambulatory surgical center, because the cost of the lens is rolled into the payment for the procedure. *Id.* However, when the procedure is performed in an office setting, the lens may be billed separately, using the code V2632 (a standard intraocular lens). Additional non-Medicare covered charges for the implantation of a presbyopia-correcting lens (other than cost of the lens) may also be reported under code V2788, effective January 1, 2007, or effective January 1, 2008, code V2787. *Id.*, §120.2.

[52] *See* R. 61 ("Premera pays for the artificial intraocular lens when billed by the facility…This supply is part of the facility expense.").

presbyopia-correcting lens was not medically necessary, because it was more costly than a standard intraocular lens.

The health care plan paid the recognized cost of a standard intraocular lens, $150, and thus the amount at issue in this case is the difference between $150 and the recognized cost of a presbyopia-correcting lens. That cost differential is unknown. The eye clinic estimated the total additional cost of implanting a presbyopia-correcting lens was $2,700, but the total was not allocated and there is no evidence in the record regarding the cost of a presbyopia-correcting intraocular lens.[53] Because Ms. C.'s claim for the cost of the lens was considered under both the vision benefit and the medical benefit, both benefits will be considered in deciding the appeal.

B. Vision Benefit Coverage

The plan's vision benefit covers "[u]p to two single vision, bifocal, trifocal, or lenticular lenses per calendar year."[54] It excludes "[m]edical or surgical treatment of the eyes" (which may be covered under the medical benefit), as well as "[s]ervices or supplies that are not necessary for…treatment of [a] vision condition…even if prescribed, recommended or approved by a vision professional."[55] The amount payable under the vision benefit is limited to the recognized charge.[56]

A presbyopia-correcting intraocular lens is not a bifocal, trifocal or lenticular lens. A presbyopia-correcting intraocular lens could reasonably be considered a "single vision" lens within the meaning of the vision benefits provision, and thus within the scope of the coverage for lenses.[57] However, in this case Ms. C. was not separately charged for an intraocular lens: the cost of her presbyopia-correcting intraocular lens was bundled into the facility's charge of $2,540 for cataract surgery. Thus, payment for the lens falls within the vision benefit's exclusion for medical or surgical treatment of the eye: the only bill that has been presented is for medical and surgical treatment, not for a lens.

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[53] Information available online suggests that the cost differential for the lens is about $750-$950. According to a June 2005 article in "Cataract and Refractive Surgery Today", the cost of a Crystalens in 2005 was $825. *Id.*, p. 36. (www.crstoday.com, accessed May 4, 2010). According to Bausch & Lomb product materials, the current cost is $895-$1,095, depending on the specific model. Bausch & Lomb Crystalens Quick Reference Guide (www.precisionlens.net/site/products/crystalens.htm, accessed May 13, 2010).

[54] Health Care Plan, p. 78.

[55] Health Care Plan, p. 79.

[56] Health Care Plan, pp. 76-78.

[57] The plan is an insurance contract; provisions regarding coverage are interpreted broadly and exclusions narrowly. *See*, State v. Arbuckle, 941 P.2d 181, 184 (Alaska 1997). Insurance contracts are interpreted to provide the coverage that a layman would reasonably expect and ambiguities are resolved in favor of the insured. *See* Makara v. Great American Insurance Co., 14 P.3d 964, 966 (Alaska 2000).

Moreover, even if a presbyopia-correcting intraocular lens had been billed separately by the clinic, Ms. C. has not shown that it was "necessary", within the meaning of the health care plan, for the treatment of either of the two vision conditions that she was treated for.[58] It was not necessary for the treatment of cataracts, because a standard intraocular lens is effective. Nor was it necessary for the treatment of presbyopia, because eyeglasses or contact lenses are effective for that purpose.

C. Medical Benefit Coverage

Although Ms. C.'s claim was initially considered and denied under the vision benefit, on review her claim was denied on the ground that it was not medically necessary, as required for coverage under the medical benefit.[59] To be medically necessary a service or supply must, in addition to improving or maintaining health or easing pain, or providing diagnostic information, be "no more costly than another service or supply (taking into account all health expenses incurred in connection with the service or supply)."[60]

Ms. C. had two independent conditions that warranted medical treatment: cataracts and presbyopia. Cataracts are treated by cataract surgery involving the removal of the cataract and implantation of an intraocular lens. A presbyopia-correcting lens is more expensive than a standard intraocular lens. Thus, such a lens is not medically necessary, within the meaning of the medical benefit, for treatment of cataracts.

Presbyopia may be treated by eyeglasses or contact lenses, or by implantation of a presbyopia-correcting intraocular lens. The total "health expenses incurred in connection" with these two options must be compared to determine which is less costly for purposes of medical necessity. The total additional cost of implanting a presbyopia-correcting intraocular lens is estimated as $2,700. Ms. C. has not shown that this is less than the total cost of purchasing eyeglasses or contact lenses to correct presbyopia, including regular replacement of the frames and lenses. Accordingly, she has not shown that the lens itself is medically necessary, within the meaning of the medical benefits provisions, for the treatment of presbyopia.

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[58] Both the medical benefit and the vision benefit include a requirement that a service or supply be "necessary." The medical benefit includes an additional requirement that the service or supply be "medically necessary", which is defined as including comparative cost. Health Care Plan, p. 18.

[59] The vision benefit does not contain an exclusion on the ground that a less expensive option is available. If a lens is "necessary for treatment", it is paid at the "recognized charge."

[60] Health Care Plan, p. 18.

IV. Conclusion

Assuming that a presbyopia-correcting intraocular lens is a "single vision" lens within the meaning of the vision benefit provisions, coverage for such a lens is excluded under the vision benefit exclusion of "medical or surgical treatment of the eye" if the charge for the lens is bundled into a facility's fee for medical or surgical treatment. Coverage for a presbyopia-correcting lens is excluded under the medical benefit because such a lens is more expensive than other alternative treatments (eyeglasses or contact lenses) for presbyopia.

The claim for payment for the additional cost of a presbyopia-correcting intraocular lens is **DENIED**.

DATED May 14, 2010.

Signed
Andrew M. Hemenway
Administrative Law Judge

Adoption

This Decision is issued under the authority of AS 39.35.006. The undersigned, in accordance with AS 44.64.060, adopts this Decision as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 22nd day of June, 2010.

By: *Signed*
Andrew M. Hemenway
Administrative Law Judge

[This document has been modified to conform to technical standards for publication.]