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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

MAR 7 1984

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Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services

Dear Dr. Davis:

Subject: Medicare Reimbursements for Conventional Eyeglasses (GAO/HRD-84-44)

We have reviewed the administration of Medicare reimbursements for cataract surgeries and prosthetic lenses by seven carriers which cover all or portions of seven States.[1] Based on our review, we believe that HCFA should discontinue Medicare part B coverage of conventional eyeglasses for patients who have undergone cataract surgery and who wear eyeglasses in front of cataract contact lenses or intraocular lenses. In such cases, we believe that eyeglasses serve the same function as they do in patients who still have the eyes' natural lenses--that is, refractive correction to improve vision--and Medicare law excludes coverage of eyeglasses for this purpose.

We estimate that the seven part B carriers we reviewed paid about $6 million in their areas for conventional eyeglasses in calendar year 1982. Medicare payments would be significantly greater nationally.

On May 20, 1983, we discussed our preliminary findings with members of your staff, and stated our intention to recommend at the completion of our review that HCFA discontinue Medicare coverage of conventional eyeglasses. Your October 28, 1983 response to this discussion expressed general concurrence with that proposed recommendation. Recently we were informed that the Bureau of Eligibility, Reimbursement and Coverage is developing a proposed regulation to discontinue coverage of

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[1]The seven carriers and States included in our review are: Blue Cross and Blue Shield of Florida (all of Florida except Dade and Monroe Counties); Transamerica Occidental Life Insurance Company (Southern California); Aetna Life and Casualty Insurance Company (Arizona); Blue Cross and Blue Shield of Alabama (Alabama); E.D.S-Federal Corporation (Illinois); Prudential Insurance Company of North America (North Carolina); and Wisconsin Physician Service (Wisconsin).

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conventional eyeglasses and desires to obtain the information we have developed. Therefore, we are reporting on this aspect of our review first.

BACKGROUND

Cataracts (any opacity or cloudiness of the natural lens of the eye) are the second leading cause of blindness in the United States. However, blindness caused by a cataract can usually be corrected through surgery to remove the diseased lens and the use of an artificial lens to restore useful vision.

Technological changes in the methods of performing cataract surgery, greater acceptance of intraocular lenses, and increases in the average longevity of Americans have contributed to a substantial increase in the frequency of cataract surgery and in Medicare payments for the correction of cataract-related blindness. An article in the September 1983 issue of the American Journal of Ophthalmology estimated that more than 600,000 cataract operations were performed in 1982. Cataract surgery is performed most frequently on persons aged 65 and older--the Medicare population.

Cataract surgery and, in some instances, congenital defects result in a condition known as aphakia, which means the natural lens of the eye is absent. Physicians may prescribe either of three types of artificial devices (prosthetic lenses) to restore useful vision in aphakic patients:

--cataract eyeglasses in single vision and bifocal models;

--cataract contact lenses in hard, soft, or extended-wear models; or

--intraocular lenses which are surgically implanted in the eye and result in a condition known as pseudophakia.

In addition, conventional eyeglasses are usually prescribed for patients with cataract contacts or intraocular lenses to provide refractive correction.

MEDICARE COVERAGE OF CATARACT-RELATED SERVICES

The Medicare program pays for cataract-related services under both its parts. Part A pays for services of institutional providers, including the inpatient services provided to cataract-surgery patients. Part A also pays for intraocular lenses when implanted in hospital inpatients. Part B pays for physician services and supplies, including the professional fees charged for cataract surgery performed on an inpatient or outpatient basis, related office visits and examinations, and prosthetic lenses.

Medicare regulations define a prosthetic device as one which replaces all or part of the function of a permanently inoperative or malfunctioning internal body organ. As a matter of interpretive policy, cataract lenses are considered prosthetic devices and are covered. Therefore, part B has been paying for cataract eyeglasses or any combination of prosthetic lenses determined by a physician to be medically necessary to restore vision after removal of the natural lens. Such combinations include

--cataract eyeglasses for near and distant vision;

--cataract contact lenses, conventional eyeglasses to be worn at the same time as the contacts, and cataract eyeglasses to be worn when the contacts are not worn; and

--intraocular lenses and conventional eyeglasses worn in front of the intraocular lenses.

Medicare does not pay for routine eye care or for conventional eyeglasses for the non-aphakic beneficiary. Medicare law from its inception specifically excluded conventional eyeglasses from coverage. Section 42 U.S.C. 1395 y (a)(7) excludes coverage of

> ". . . eyeglasses 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 eyes, . . ."

We estimate that the Medicare carriers we reviewed allowed charges totaling about $7.8 million in calendar year 1982 for conventional eyeglasses worn by aphakic and pseudophakic beneficiaries (see Appendix). This represents Medicare payments of about $6 million in these areas because Medicare generally pays 80 percent of allowed charges[2]. Significantly greater amounts would have been paid nationally.

CONVENTIONAL EYEGLASSES PROVIDE REFRACTIVE CORRECTIONS

Cataract contacts or intraocular lenses replace the function of the natural lens of the eye, whereas conventional eyeglasses worn with these prosthetic lenses provide a refractive correction of the restored vision. Virtually all cataract-surgery patients who have cataract contacts or intraocular lenses use conventional eyeglasses because the prosthetic lenses are fitted to provide normal distant vision and are not "focused" for near vision. However, the natural

[2]The annual deductible of $75 would generally be exceeded by other services provided to a beneficiary who has undergone cataract surgery.

lenses of non-aphakic persons usually decline in focusing ability with age, making eyeglasses necessary for near vision. The American Optometric Association reports that about 92 percent of the population over 65 has vision problems severe enough to require eyeglasses.

CONCLUSION

In our opinion, conventional eyeglasses worn by the aphakic or pseudophakic patient perform the same refractive function as eyeglasses worn by the non-aphakic patient. Because coverage of conventional eyeglasses which provide refractive correction is specifically excluded under Medicare, covering such eyeglasses for aphakic and pseudophakic beneficiaries is inconsistent with Medicare law.

RECOMMENDATION

We recommend that you discontinue Medicare payments for conventional eyeglasses for aphakic and pseudophakic beneficiaries.

OBJECTIVE, SCOPE, AND METHODOLOGY

We initiated our review of cataract-related services provided to Medicare beneficiaries because of the increasing use of cataract surgery, interest in the effectiveness of prosthetic devices, and concern about Medicare payments for health care. The objective of the portion of our review addressed by this report was to determine the extent of payments for conventional eyeglasses provided to Medicare beneficiaries after cataract surgery.

To determine the potential savings of Medicare funds if coverage of conventional eyeglasses were discontinued, we developed actual or estimated allowed charges for such eyeglasses by the seven carriers. At each carrier, we identified specific procedure codes, if available, assigned to eyeglasses worn in front of contacts or intraocular lenses. Carriers in Alabama, Florida, Illinois and North Carolina, provided the amounts allowed for the specific codes used to denote conventional eyeglasses during calendar year 1982. As shown in the appendix, these amounts totalled $3.963 million.

We also developed, in consultation with medical representatives, other ways to identify payments for conventional eyeglasses. At our request, each carrier identified the universe of beneficiaries having claims for prosthetic lenses during calendar year 1982. From each universe, we obtained a random sample of beneficiaries and reviewed the paid claims history of each to determine if claims for conventional eyeglasses were included. For example, those lenses claimed in addition to intraocular lenses, or lenses classified as cataract lenses but having a power of no greater

than four diopters, were considered to be conventional eyeglasses. When necessary, we reviewed copies of individual claims or contacted providers to confirm whether items provided were cataract eyeglasses or conventional eyeglasses. As shown in the appendix, we projected that about $3.8 million (plus or minus $.5 million) was allowed for such claims in calendar year 1982.

Our work was done in accordance with generally accepted government audit standards.

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We are sending copies of this letter to the Director, Bureau of Eligibility, Reimbursement and Coverage. We would appreciate hearing from you within 30 days on whatever action you take or plan on our recommendation.

Sincerly yours,

Thomas Dowdal

Thomas Dowdal
Group Director

REASONABLE CHARGES ALLOWED FOR CONVENTIONAL EYEGLASSES DURING CALENDAR YEAR 1982
IN AREAS SERVED BY SELECTED CARRIERS

Area	Charges allowed for procedure codes identifying conventional eyeglasses		Estimated charges allowed based on additional codes identified in sample		Total		Confidence limits at 95 percent level (note a)	
	Number of services	Amount allowed	Number of services	Amount allowed	Number of services	Amount allowed	Number of (+)services	Amount (+)allowed
Alabama[b]	3,221	$ 211,328	1,256	$ 93,036	4,477	$ 304,364	407	$ 33,697
Arizona[c]	- -	- -	5,955	216,888	5,955	216,888	1,059	31,450
Florida[b] (exc. Dade and Monroe counties)	46,792	3,117,145	7,090	596,326	53,882	3,713,471	3,853	359,153
Illinois[b]	4,177	254,568	12,606	843,116	16,783	1,097,684	3,098	201,193
North Carolina[d]	10,273	380,004	- -	- -	10,273	380,004	- -	- -
California (seven southern counties only)[c]	- -	- -	49,363	1,824,937	49,363	1,824,937	9,560	263,000
Wisconsin[e]	- -	- -	4,840	236,982	4,840	236,982	1,529	72,159
Totals	64,463	$3,963,045	81,110	$3,811,285	145,573	$7,774,330	10,930[f]	$495,953[f]

[a] The plus or minus ranges shown relate to the estimates but may also be applied to totals.

[b] These states had specific codes for conventional eyeglasses. However, in our sample we found claims for cataract eyeglasses for beneficiaries with IOL implants. We determined that these too were conventional eyeglasses.

[c] These states had identifiable codes, but total allowances were not available. Thus, we developed the information needed from random samples.

[d] Represents only the amount for identifiable codes. No other cases involving conventional eyeglasses were identified in our sample.

[e] Wisconsin did not have codes for conventional eyeglasses. We considered eyeglasses to be conventional if the claim indicated they were to be worn with an IOL or cataract contact.

[f] This figure represents a weighted total rather than a summation of the column.