



Corcoran
Consulting
Group

A Division of Ardare Corporation

**Medicare Reimbursement
for
Astigmatic Keratotomy**

*Prepared for
OASIS Medical, Inc.*

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Medicare Reimbursement for Astigmatic Keratotomy

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Objective: *This report is provided as a general discussion of Medicare reimbursement for astigmatic keratotomy. Local variations between carriers may occur which are not described here. The user is strongly encouraged to review official instructions promulgated by the Centers for Medicare and Medicaid (CMS) and their Medicare carriers; this document is not an official source nor is it a complete guide on all matters pertaining to reimbursement. In addition, users should check with their local insurance carriers for approved diagnosis codes and usage guidelines for the services discussed.*

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Disclaimer: *The reader is reminded that this information can and does change over time, and may be incorrect at any time following publication.*

INTRODUCTION

The options available to manage refractive errors include spectacles, hard contact lenses, soft contact lenses, and a variety of surgical procedures. For the patient with an operable cataract and astigmatism, combining a cataract extraction with intraocular lens implant and astigmatic keratotomy (AK) can reduce or eliminate reliance on postoperative corrective lenses. This is an attractive option for patients, but there are several clinical and reimbursement considerations to be addressed before scheduling surgery.

MEDICARE REIMBURSEMENT AND ASTIGMATIC KERATOTOMY

Medicare pays for a wide variety of services including surgery, but there are indications and limitations of coverage. Reimbursement is made for those services Medicare believes to be medically necessary. Medicare's empowering legislation is contained in the Social Security Act and includes §1862(a)(1) which states that "...no payment may be made under Part A or Part B for any expenses incurred for items or services which. . . are not reasonable and necessary for the diagnosis or treatment of illness..."

Medicare does not pay for cosmetic or refractive surgery except in rare instances when refractive surgery may be covered to correct a surgical complication (MCPM, Chapter 12, §40.1B) or treat the resulting refractive error due to trauma (Transmittal 99). This regulation is based on a statutory provision contained in the Social Security Act §1862(a)(10) which states that "...no payment may be made under Part A or Part B for any expenses incurred for items or services...where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member". Refractive surgery performed solely to reduce the patient's dependence on eyeglasses or

contact lenses would be considered cosmetic in Medicare's view and therefore excluded from coverage. Furthermore, the Medicare National Coverage Determinations Manual (NCD) contains specific instructions about refractive surgery in NCD §80.7 which specifies that "...keratoplasty for the purpose of refractive error compensation is considered a substitute or alternative to eyeglasses or contact lenses, which are specifically excluded . . . keratoplasty to treat refractive defects are not covered." AK is a form of keratoplasty, and corneal relaxing incisions (CRI) or limbal relaxing incisions (LRI) are two commonly known AK procedures.

Astigmatism can be either *iatrogenic* or *pre-existing*. *Iatrogenic* astigmatism is *induced* by the effects of treatment, usually surgery. A *pre-existing* astigmatism is *not* induced by a previous surgery.

The CPT handbook describes two procedures to correct iatrogenic astigmatism:

65772 *Corneal relaxing incision for correction of surgically induced astigmatism.*

65775 *Corneal wedge resection for correction of surgically induced astigmatism.*

In general, wedge resection is used to correct large amount of astigmatism while relaxing incisions are used for smaller corrections.

The mere existence of iatrogenic astigmatism does not automatically make astigmatic correction a covered service. Before all elective surgeries, patient lifestyle complaints along with trial and failure of prior treatment need to be well documented in the patient record. Examples, of patient complaints are: *monocular diplopia interfering with driving and reading, or unable to wear contact lens due to poor comfort*. The clinical notes would include discussion regarding trial of spectacles, and contact lenses without success. The following case study represents a patient with iatrogenic astigmatism and medically necessary CRI.

Figure 1 Medicare Covered AK Procedure

CASE STUDY IATROGENIC ASTIGMATISM	
Pre-operative Dx: Pre-op refraction:	Clinically significant cataract -4.50 +1.25 x 90
Post-op refraction: Patient complaint:	-0.50 +4.25 x 95 CL intolerance and poor night vision interfering with driving
Failure of prior Tx:	Spectacles with or without slab off = significant ghosting @ distance and diplopia @ near. Multiple CL trials with poor comfort and manual dexterity problems for patient on insertion and removal.
Post-op Dx:	Surgically induced corneal astigmatism with failure of conventional treatment and patient complaints about restrictions on activities of daily living.
Plan:	Arcuate corneal relaxing incisions

This patient had an increase of 3.00D of astigmatism following cataract surgery. The surgeon should seek reimbursement from Medicare for this procedure. Note: In rare cases the increase in astigmatism may be the net change from with-the-rule (+1.50 x 90) to against-the-rule astigmatism (+1.50 x 180) for a net total of 3.00 D. This may still render AK a covered service.

Very few Medicare carriers have Local Coverage Decisions (LCDs) that specify the amount of surgically induced astigmatism required in order to be eligible for reimbursement. The LCDs that do exist have varying thresholds for coverage (see Table 1).

In most states, it is unclear what the criteria are for Medicare coverage of AK. In cases where coverage is uncertain, an Advanced Beneficiary Notice (ABN) is warranted (see Appendix).

An ABN is a written notice a physician or supplier gives to a Medicare beneficiary before items or services are furnished, when the physician or supplier believes that Medicare probably or certainly will not pay for some or all of the items or services because they are not medically necessary.

In June, 2002, CMS published an official ABN (Form CMS-R-131-G) that you must use. An ABN is required for both assigned and non-assigned claims. Submit your claim with modifier GA appended to the appropriate CPT or HCPCS code.

The new ABN form was mandated as part of HIPAA (See Appendix). Medicare has published a requirement that claims be filed whenever an ABN is obtained (PM AB-02-114). The mandatory claims filing requirement was effective January 1, 2003.

By signing an ABN, the Medicare beneficiary acknowledges that he or she has been advised that Medicare will probably or certainly not pay, and agrees to be responsible for payment, either personally or through another insurance. Medicaid qualifies as “other insurance” so get an ABN even for Medi/Medi patients.

Table 1 Local Coverage Decisions

State	Carrier	Diopters
New Jersey	Empire	Individual review
Pennsylvania	HGSA Administrators	Not noted

Note: This list of policies is valid as of March 21, 2005 and is subject to change.

The ABN must be signed before you provide the items or services. Keep the original in your file and provide a copy to the patient. The “Estimated Cost” field is optional. The patient must *personally* choose either Option 1 (yes) or Option 2 (no). The patient must *sign* and *date* the form; an unsigned form is not valid. Without the Medicare beneficiary’s advance acceptance

of financial responsibility, you will be required to refund any payment you collected.

You do not need an ABN for services that are statutorily (by law) non-covered by Medicare. Statutorily non-covered services in an eye care practice include refractions and cosmetic surgery. A Notice of Exclusions from Medicare Benefits (NEMB) form, notifies the beneficiary that this service is non-covered, and that the patient will be responsible for the charges associated with the procedure. For non-Medicare beneficiaries, a Notice of Exclusion from Health Plan Benefits (NEHB) serves the same function (see Appendix). By signing a form, the beneficiary accepts financial responsibility for AK.

Pre-existing astigmatism is not an indication for either of the two procedures described above. The CPT handbook does not have a specific code to describe AK on an eye with pre-existing astigmatism not surgically induced. A miscellaneous code, 66999, is the only code available to describe surgery for pre-existing astigmatism.

66999 *Unlisted procedure, anterior segment of the eye*

The following case study (Figure 2) represents a patient with a pre-existing astigmatism that was not iatrogenic.

Figure 2 **Non-Covered AK Procedure**

CASE STUDY PRE-EXISTING ASTIGMATISM	
Pre-op Dx:	Visually significant cataract and corneal astigmatism
Pre-op refraction:	-4.50 +2.25 x 90
Post-op refraction:	-0.50 +2.00 x 95
Post-op Dx:	Corneal astigmatism (not iatrogenic)
Plan	Arcuate limbal relaxing incisions

In this case, the patient presents with 2D of astigmatism postoperatively. The astigmatism was not surgically induced. The physician should seek reimbursement from the patient for the surgical correction by AK. An ABN is not required in this case but notifying the patient of required payment is in the best interests of both the patient and the practice. Before the operation, and during the informed consent, ask the patient to sign an NEMB.

This patient (Figure 3) presents for cataract surgery with significant astigmatism in the preoperative refraction and elects to have AK at the time of cataract surgery. Even though the amount of astigmatism is large, Medicare only reimburses for the cataract surgery; and the patient would be responsible for payment of the AK procedure. Again, an ABN is inappropriate but an NEMB is advised.

Figure 3 **Non-Covered AK Procedure**

CASE STUDY PRE-EXISTING ASTIGMATISM COMBINED PROCEDURE	
Pre-op Dx:	Visually significant cataract and pre-existing corneal astigmatism
Pre-op refraction:	-4.50 +4.25 x 90
Plan:	Cataract extraction w/IOL and Arcuate limbal relaxing incisions

Figure 4 is an example of the surgeon's claim for a combined procedure of AK and cataract extraction. Add modifier GY to procedure code 66999 on the CMS-1500 claim form to notify the carrier that you performed a statutorily excluded procedure, and the beneficiary requested the physician to file a claim anyway. Filing a claim for an excluded procedure is useful, but not mandatory, because the explanation of benefits (EOB) sent to the patient shows that the procedure is not covered. Some patients have supplemental insurance that might cover the procedure.

Figure 4 Claim Form for Concurrent Surgeries

17.		17.a.					
19. Cosmetic surgery exclusion; seeking denial for secondary payer							
21. 1. 366.16 Nuclear Sclerotic Cataract 2. 367.21 Regular Astigmatism							
24.a	24.b	24.c	24.d	24.e	24.f	24.g	24.k
MM/DD/YYYY			66984 RT	Cataract extraction with IOL	1	\$\$\$\$\$	1
MM/DD/YYYY			66999 GY	Astigmatic keratotomy	2	\$\$\$\$\$	1

DIAGNOSIS

Figure 5 lists some of the ICD-9 codes that can be associated with AK.

Figure 5 Diagnoses and ICD-9 Codes

Diagnosis	Code
Pseudophakia	V43.1
Post corneal transplant	V42.5
Regular astigmatism	367.21
Irregular astigmatism	367.22
Complication of corneal graft	996.51
Complication of ocular lens prosthesis	996.53

Regular astigmatism occurs when the principle meridians are orthogonal or 90° apart from each another. Glasses often can correct this type of astigmatism although, if anisometropia exists, surgical correction of the astigmatism may be indicated. Irregular astigmatism occurs when the two principle meridians are not separated by 90°, and correction cannot be accomplished with glasses; only hard contact lenses or surgical intervention are effective. Irregular astigmatism is seen in patients with keratoconus, some corneal degenerations such as pellucid marginal degeneration, and corneal scarring, but rarely found in otherwise healthy eyes.

If an eye develops astigmatism (regular or irregular) as a complication of prior ocular surgery and the vision cannot be corrected by conventional means such as eyeglasses or contact lenses, refractive surgery may be indicated. The Medicare claim for AK includes astigmatism as the primary diagnosis code as well as a supplemental diagnosis further describing the reason for the medically necessary procedure. It may be helpful to submit additional information that supports the claim such as the operative report, pre- and postoperative refraction, corneal topography, and a description of other failed treatments such as glasses or contact lenses.

REIMBURSEMENT

Physician

In 2006, the national Medicare Physician Fee Schedule is reduced 14% for 65772 when performed in a location other than the physician's office. The reduced national allowed amount is \$327.07. The allowable for 65775 is not subject to a reduction when performed in a facility. (see Table 2)

Facility

The hospital outpatient department (HOPD) or ambulatory surgery center (ASC) may also make a charge for AK. In the typical case involving pre-existing astigmatism, Medicare would not

reimburse either the HOPD or ASC. The patient would be responsible for those charges as well.

However, if the AK corrects a surgically induced astigmatism, Medicare reimburses both the HOPD and ASC. 65772 and 65775 performed in a HOPD, fall under APC 233. Medicare's national payment rate for APC 233 effective January 1, 2006 is \$872.70. (see Table 2)

Effective July 1, 2003, 65772 and 65775 are included in the list of procedures for which an ASC facility fee is payable under Medicare's regulations. Under current Medicare regulations, 65772 and 65775 are eligible for reimbursement of an ASC facility fee under group 4, with a national reimbursement rate of \$630.00 (effective April 1, 2004) (see Table 2).

Table 2 Medicare Payment for 65772 and 65775

	65772	65775
Physician (in office)	\$380.49	\$455.91
Physician (in facility)	\$327.06	\$455.91
ASC (Group 4)	\$630.00	\$630.00
HOPD (APC 233)	\$872.70	\$872.70

UTILIZATION

Refractive surgery and other procedures to correct postoperative complications following cataract should be rare. Medicare does not expect to pay for many such procedures. In 2004, Medicare only paid for this procedure 3,750 times. If complications do occur frequently, the Peer Review Organization (PRO) is likely to investigate. The focus of this type of investigation is the quality of care provided to beneficiaries. Sometimes reimbursement is challenged if the PRO believes that the wrong CPT code was used to describe the surgery in order to obtain payment under false pretense.

LEGAL CONSIDERATIONS

Cataract surgery is a covered benefit under Medicare regulations provided there is adequate medical necessity to justify the procedure. If a surgeon offers "free refractive surgery" as an inducement to have cataract surgery, Medicare would object and there may be serious legal consequences. Conversely, if the surgeon considers AK to be an *incidental* part of the cataract operation (and not separately reported), then the legal stigma is removed. For many ophthalmologists, there are enough surgical bundles inhibiting reimbursement; this is one time where the surgeon can choose his own fate.

CONCLUSION

AK alone or combined with cataract surgery provides an excellent means to restore uncorrected vision. Since the Medicare regulations are complex, the mechanism of reimbursement is not always clear.

In most cases, astigmatism is pre-existing and not iatrogenic, and AK is not covered by Medicare; the surgeon and the facility may charge the patient for the surgery. In a few cases, AK may be performed to correct a surgical complication and Medicare will cover the procedure. Consequently, AK provides a means to enhance patient satisfaction and practice revenue at the same time.

APPENDIX

(Customize top of form with name, address & phone)

(Provide 1 copy to patient, keep original in your files.)

Patient's Name:

Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case **Medicare probably will not pay for -**

Items or Services:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: \$** _____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

Option 1. YES. I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

Option 2. NO. I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date

Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this Form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form May be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

(Customize top of form with name, address & phone)

(Provide 1 copy to patient, keep original in your files.)

Patient's Name:

Medicare # (HICN):

NOTICE OF EXCLUSION FROM MEDICARE BENEFITS (NEMB)

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them.
- When you receive an item or service that is not a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why Medicare won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: \$**_____)

Medicare will not pay for:

Astigmatic keratotomy for the purpose of refractive error compensation.

Because of the following exclusion from Medicare benefit:

In National Coverage Determination §80.7 which specifies that "...keratoplasty for the purpose of refractive error compensation is considered a substitute or alternative to eyeglasses or contact lenses, which are specifically excluded . . . keratoplasty to treat refractive defects are not covered."

Your doctor has recommended the following cosmetic refractive surgery after determining that you are a good candidate for the procedure. You do not need this surgery; it is optional. If you elect not to have the surgery, you will probably be dependent on eyeglasses or contact lenses to cope with your refractive error.

I understand and agree.

Date

Signature of patient or person acting on patient's behalf

(Customize top of form with name, address & phone)

(Provide 1 copy to patient; keep original in your files.)

Patient's Name: _____

NOTICE OF EXCLUSION FROM HEALTH PLAN BENEFITS (NEHB)

You need to make a choice about having astigmatic keratotomy, a form of cosmetic refractive surgery. This procedure is not a covered benefit and consequently your health plan will not pay for it. When you receive an item or service that is not a covered benefit, you are responsible to pay for it.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully. **Ask us to explain, if you don't understand why your health care service plan won't pay.**

Your doctor has recommended astigmatic keratotomy after determining that you are a good candidate for the procedure. You do not need this surgery; it is optional. If you elect not to have the surgery, you will probably be dependent on eyeglasses or contact lenses to cope with your refractive error.

You are responsible for all of the fees associated with non-covered items and services. The charge for the surgeon's professional fee is \$_____ and the charge for hospital or ASC facility fee is \$_____.

Beneficiary Agreement

Accordingly, the undersigned accepts full financial responsibility for the non-covered services described above.

Signature of patient or person acting on patient's behalf

Date

