SightLife
The World Through New Eyes®

# Corneal Tissue Processing and Acquisition Billing Primer

*Answers to Frequently Asked Questions for Your Billing Department*

This primer is meant to provide facilities that are performing corneal transplants with information regarding how to properly bill for reimbursement through Medicare. Eye banks are not Medicare providers and their services are to be billed as a pass through paid at cost (the invoice).

Hospitals and ambulatory surgical centers (ASCs) report HCPCS code V2785 when billing for the costs of acquiring corneal tissue. This code includes tissue recovery, evaluation, medical review and laboratory tests for infectious disease, processing, and transportation.

## FOR HOSPITALS

V2785 is paid at-cost basis according to the invoice provided by the eye bank. Invoices should be retained for three year for evidence in case of CMS audit.

## FOR AMBULATORY SURGICAL CENTERS

V2785 may be billed separately or as an add-on to ASC-allowable surgical procedure codes for keratoplasty. ASCs must submit a copy of the eye bank invoice along with the claims form, either electronically or via paper.

Refer to page four in the Hospital Outpatient Prospective Payment System and page three of the Ambulatory Surgical Center Fee Schedule, in the advocacy section below, for a citation of this policy.

| Keratoplasty surgical codes that should include V2785 | CPT |
|---|---|
| **Penetrating Keratoplasty (PK) in aphakia** | 65730 |
| **PK phakic** | 65750 |
| **PK pseudophakic** | 65755 |
| **Anterior Lamellar Keratoplasty (ALK)** | 65710 |
| **Endothelial Keratoplasty (EK)** | 65756 |
| **Keratoprosthesis** | 65770 |

## BACKBENCH PREPARATION

Tissue precut by the eye bank includes the cost of backbench preparation in the eye bank invoice charge. Tissue preparation done by the surgeon should be reported with surgical CPT code 65757.

## BILLING FOR TISSUE PROVIDED AS BACK UP

Occasionally, surgeons will request a second cornea (back up tissue) to be used in case a first transplant surgery fails. Medicare policies define how this should be reflected in coding the surgical procedures.

The first procedure is coded with modifier 74 to report the fact that it was interrupted while the patient was under anesthesia. This billing code must also account for the cornea used in the aborted procedure. It must include the V2785 item.

The second procedure is coded as normal. This procedure should include a V2785 code to account for the backup tissue. The second procedure is subject to discounting policies of the professional, OPPS, and ASC fee schedules, but the costs associated with V2785 should be fully reimbursed.

If the backup tissue is not used in surgery, it should be returned to SightLife and NOT be included in any procedural coding.

Refer to section 40.4 in the Medicare Claims Processing Manual. See the advocacy section below.

## FEMTOSECOND LASER-ASSISTED KERATOPLASTY (FLAK):

CMS policy recognizes two tracking codes for preparing grafts with femtosecond lasers. A tracking code allows CMS to collect data about cost and usage of new procedures. CMS does not assign payment to tracking codes, so reimbursement is at the discretion of the insurance carrier.

You should not expect to this service to reimbursed by Medicare carriers, so you may want to have a Medicare beneficiary who opts for FLAK surgery to sign an Advance Beneficiary Notice that payment for the service would be denied (if you do that, note the modifier GA on your claim).

> **+0289T** indicates femtosecond laser preparation of the donor graft. This code should be reported when the physician prepares tissue, not when an eye bank cuts with a femtosecond laser
>
> **+0290T** is used for a femtosecond laser incision in the recipient's cornea.

These tracking codes modify the anterior lamellar (ALK) and penetrating keratoplasty (PK) CPT codes in the table above (65710, 65730, 65750, and 65755). Femtosecond endothelial graft preparation can be reported when the physician prepares the graft and 65757 (backbench preparation of graft tissue) is included on claim.

## BE AN ADVOCATE FOR YOUR PRACTICE

Contact your Medicare Administrative Carrier (MAC) if you experience problems with claiming fair reimbursement. Their job is implement Medicare policy and process claims for service provided to Medicare beneficiaries
The following resources may be helpful in discussions with your MAC:

**Hospital Outpatient Prospective Payment System**
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf

**Ambulatory Surgical Center Fee Schedule**
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AmbSurgCtrFeepymtfctsht508-09.pdf

**The Medicare Claims Processing Manual**
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf

If you have any further questions, or if you want an audit of your facility's performance, SightLife is here to help.

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