Corneal Tissue Processing and Acquisition Billing Primer

How to properly bill for reimbursement through Medicare.

CorneaGen™

Overview

At CorneaGen, we are advocates for you and your patients. We're committed to removing systemic barriers that limit patients' access to care and surgeons' ability to provide the best corneal treatments to their patients.

To ensure patients have access to a high standard of care, CorneaGen analyzed trends in Medicare insurance claims data and found that 45 percent of the time hospital outpatient departments did not submit any charge to Medicare for corneal tissue. Failure to claim Medicare reimbursement can lead hospitals to conclude that corneal transplant procedures are not cost effective, distorting the total costs of corneal graft procedures and causing them to limit corneal surgeries.

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 Healthcare Common Procedure Coding System (HCPCS) code V2785 when billing for the costs of acquiring corneal tissue. This code includes tissue processing, laboratory tests for infectious disease, and transportation.

> **For hospitals:** To receive cost-based reimbursement, submit charges for corneal tissue acquisition using HCPCS code V2785.
>
> **For ASCs:** V2785 may be billed separately or as an add-on to ASC-allowable surgical procedure codes for keratoplasty. ASCs must submit an electronic or paper copy of the eye bank invoice along with the claims form.

For a citation of the above policy, please refer to the ***Hospital Outpatient Prospective Payment System (Pg. 4)*** and the ***Ambulatory Surgical Center Fee Schedule (Pg. 3)***. See the advocacy section below for links to the documents available on the Centers for Medicaid & Medicare Services website.

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 pre-cut 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. Please note that CPT code 65757 is a (+) add on code and should be listed separately in addition to the primary CPT code for the transplant surgery.

Billing for Tissues Provided For Back Up In The Event Of A Failure During Surgery:

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 CorneaGen 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.

Advocacy

We are advocates for you and your patients and are committed to removing systemic barriers that limit patients' access to care and surgeons' ability to provide the best corneal care. That is why we offer free reimbursement consultation services through NMD HealthCare Consulting who will help with coding, coverage and reimbursement inquiries.

The NMD Healthcare Reimbursement Hotline telephone number is: 609-584-8470 and email address is **support@nmdhealthcare.com**

Additional Resources:

Hospital Outpatient Prospective Payment System

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf

Ambulatory Surgical Center Fee Schedule

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AmbSurgCtrFeepymtfctsht508-09.pdf

The Medicare Claims Processing Manual

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf

Disclaimer:
All customers be aware that coverage and reimbursement can change and private payer policies can be different from Medicare depending on a provider's contract. Contact payers directly for reimbursement information and instructions.