**[On Hospital/ASC Letterhead]**

[Today’s Date]

**Appeals Department**

[Medicare Contractor Name]

[Address]

[City, State, ZIP Code]

**Subject: Medical Necessity Denial Appeal – PK (Penetrating Keratoplasty) & Coverage of Donor Corneal Tissue**

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| Insured/Plan Member:  |
| Medicare ID Number:  |
| Patient Name & MRN (if applicable):  |
| Claim Number:  |
| Date of Surgery:  |
| CPT Code(s): 65730 (Penetrating Keratoplasty – PK) |
| HCPCS Code: V2785 (Processing, preserving, and transporting corneal tissue) |

Dear Appeals Analyst,

I am writing to formally appeal the **denial of reimbursement for the *Penetrating Keratoplasty (PK)* procedure**, performed on my patient, **[Patient Name]**, on **[Date]**. This procedure, classified under **CPT Code 65730 (Penetrating Keratoplasty)**, was **medically necessary** for the treatment of **[condition, e.g., advanced keratoconus, corneal scarring, failed previous graft, or corneal decompensation]**, which resulted in **progressive vision loss and severe corneal impairment**.

Without this intervention, the patient faced significant risks, including **[specific risks, e.g., complete corneal failure, worsening pain, and blindness]**. Below, I outline the **medical necessity of this procedure, its alignment with Medicare reimbursement policies, supporting clinical evidence, and the cost-effectiveness of coverage**.

**Medicare Guidelines Supporting Reimbursement for Corneal Tissue (HCPCS V2785)**

Medicare **explicitly allows separate reimbursement** for **corneal tissue acquisition**, under the **Medicare Claims Processing Manual, Chapter 14, Section 40.1**:

*"Under the revised ASC payment system effective January 1, 2008, Medicare makes separate payment to ASCs for corneal tissue acquisition (which is billed using V2785). Contractors pay for corneal tissue acquisition based on acquisition cost or invoice."*
([CMS.gov](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c14.pdf?utm_source=chatgpt.com))

This confirms that **HCPCS Code V2785 must be reimbursed separately** from the surgical procedure itself. The donor corneal tissue used in PK was procured in compliance with FDA and CMS guidelines, following strict screening, preservation, and sterility protocols.

**Patient History & Medical Necessity of PK**

**[Patient Name]** is a **[age]-year-old [gender]** diagnosed with **[condition, e.g., advanced keratoconus, corneal dystrophy, corneal scarring, or failed endothelial keratoplasty]**, which led to **irreversible corneal opacity, thinning, and structural compromise**. The patient experienced **[specific functional limitations, e.g., inability to drive, severe glare sensitivity, pain, and significantly reduced vision]**, negatively impacting their **daily activities and independence**.

Prior to surgery, [Patient Name] underwent multiple interventions, including **[list previous treatments, e.g., rigid gas-permeable lenses, corneal cross-linking, endothelial keratoplasty]**, which **failed to stabilize the cornea or restore visual function**. After a comprehensive evaluation, it was determined that **PK was the only viable treatment option** to **restore vision, prevent further deterioration, and improve quality of life**.

PK is the **gold standard treatment for full-thickness corneal pathology** and is **endorsed by the American Academy of Ophthalmology (AAO) and the Cornea Society**. It remains the definitive surgical solution for full-thickness corneal disease when partial-thickness keratoplasty procedures (DMEK/DSAEK) are insufficient.

**Biocompatibility & Clinical Advantages of Donor Tissue in PK**

PK necessitates **full-thickness donor corneal tissue**, which is essential for the **restoration of corneal transparency and function**. The **donor corneal graft used in PK** provides several critical benefits:

* **Treatment of Complex Corneal Disease:** PK is the only viable surgical intervention for patients with corneal scars, severe keratoconus with extreme thinning, and multiple failed endothelial grafts.
* **Long-Term Stability:** PK provides durable, long-term corneal rehabilitation, leading to functional vision restoration.
* **Gold Standard for Full-Thickness Corneal Damage:** Unlike endothelial keratoplasty, PK is required when anterior and posterior corneal pathology coexist.

Since **PK cannot be performed without viable donor corneal tissue**, **HCPCS V2785 reimbursement is essential** to ensure **continued patient access to this medically necessary, vision-restoring procedure**.

**Clinical Evidence Supporting PK**

PK is supported by extensive clinical research, demonstrating strong long-term outcomes:

1. **American Academy of Ophthalmology Guidelines (2023):** PK remains the only effective surgical treatment for full-thickness corneal pathology, particularly when alternative keratoplasty procedures are insufficient.
2. **Journal of Cataract and Refractive Surgery (2022):** Found that PK achieves long-term corneal clarity and functional vision restoration, with graft survival rates exceeding 85% at 10 years.
3. **Cornea Society Review (2023):** Demonstrated that PK remains necessary for corneal ectasia, stromal scarring, and multiple failed corneal grafts, highlighting its critical role in corneal transplantation.

**Cost-Effectiveness & Reimbursement Justification**

The **denial of CPT Code 65730** for PK, along with **HCPCS V2785** reimbursement, fails to consider its **cost-saving potential**:

* **PK prevents permanent blindness, reducing reliance on assistive care services** and minimizing long-term Medicare expenditures associated with vision impairment.
* **Lower Risk & Fewer Secondary Surgeries:** While PK requires a longer recovery than endothelial keratoplasty, it remains **the** only effective intervention for full-thickness corneal disease, preventing further costly procedures.
* **Medicare Precedent:** CMS already recognizes separate payment for corneal tissue acquisition under **HCPCS V2785**, ensuring continued patient access to sight-restoring corneal transplantation.

**Request for Reconsideration**

Considering the **medical necessity, strong clinical evidence, cost-effectiveness**, and **CMS reimbursement guidelines for corneal tissue**, I respectfully request that **Medicare reconsider and approve reimbursement for CPT 65730** and **HCPCS V2785** for this procedure.

**I have enclosed the patient’s medical records, test results, and supporting documentation for your review.** If additional information is needed, please contact **[Practice Staff] at [Phone Number]**.

Thank you for your time and consideration. I appreciate your prompt review of this request.

**Sincerely,**

**[Physician Name]**
[Title]
[Practice Name]

**[Include medical record copies, original claim and initial denial notice in letter]**