



2026

# Corneal Tissue Processing and Acquisition Billing Primer

How to properly bill for reimbursement



# We're Here to Help

CorneaGen is pleased to provide customers with medical claims assistance to help with billing corneal tissue to local Medicare and commercial insurance providers. Our internal resources, in conjunction with 3rd party Ophthalmology insurance consultation experts, will help with coding, coverage, and reimbursement best practice inquiries.

This primer is meant to provide facilities that are performing corneal transplants with information regarding how to effectively bill for reimbursement through Medicare and commercial payers.

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## How to Bill Most Insurance Payers

Eye Banks are not Medicare providers. Their donor tissue services are billed as a pass-through expense payable at total invoice cost.

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 represents the acquisition cost of corneal tissue, including processing and preservation services performed by the eye bank in accordance with CMS guidance. Facilities should report the actual invoice cost, subject to payer-specific reimbursement methodology and documentation requirements.

1. **For hospitals:** To receive cost-based reimbursement, submit charges for corneal tissue acquisition using **HCPCS code V2785** which has a Medicare Status Indicator "F" meaning that corneal tissue is paid at a reasonable cost, but not through the Outpatient Prospective Payment System (OPPS) program.
2. **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. Please be aware that there are many MACs with policies in place that specifically require billing V2785 for claims reporting of corneal tissue.
3. Please be aware that **additional facility information** may be required by Medicaid or Private Payers.
4. For commercial payers, CorneaGen suggests Prior Authorization of benefits for any new facility or first-time insurer/payer to identify any reimbursement concerns prior to procedure.

To perform a **PA**, facilities typically must submit required demographic, clinical, and insurance documentation necessary for payer review. This may include copies of patient's insurance card (front and back, patient diagnosis and supporting medical necessity information consistent with payer requirements).

Also, most if not all commercial payers have their own Pre-Authorization letter that is required to be completed by the customer. CorneaGen recommends reaching out to the individual payer to request their specific Pre-Authorization letter. If the payer does not have a standardized format, CorneaGen offers comprehensive options for your use.

5. We offer a proactive review in advance of the claim being submitted to the payer to ensure all required data is completed and included in the fields/ form locators, filled out properly / correctly on both/either the 1450 (HOPD) or the 1500 (ASC).

If you are experiencing any reimbursement issues or payer gaps, please reach out directly to CorneaGen at [Contracts@CorneaGen.com](mailto:Contracts@CorneaGen.com) for a prompt follow up.

## Exceptions

Some regional commercial insurance providers outsource bill processing of corneal tissue to a 3rd party health plan administrator. Those administrators may require different coding than V2785. A list of commercial insurance companies known to use a third-party administrator is below. For those listed in the regions below, it is encouraged to review your insurance contract for billing procedures or contact CorneaGen at [Contracts@CorneaGen.com](mailto:Contracts@CorneaGen.com) so we can help you connect with the appropriate personnel at the Administrator's office.

**Aetna** - Nationwide

**Anthem** - CA, NV, GA, OH, NH, CT, IN

**BCBS** - FL, NC

**CBC** - PA

## Renegotiating Commercial Payer Contracts

Have you considered renegotiating your commercial payer contract to improve payment for tissue?

If you are interested in renegotiating your contract, we make the following recommendations:

- Start the process with the insurance provider 90-120 days minimum before contract end date
- Always negotiate the HCPCS code, V2785, in your payer contract to be payable at Eyebank invoice value to ensure the full invoice will be covered in your contract.
- For a smaller surgery center, focus on the 10-15 CPT codes with the highest revenue impact for the organization within the negotiation to get the biggest impact. Consider future business strategy within the scoping in case the insurance company does not allow for annual renegotiations.
- Make sure to highlight higher cost cases (like implants) within the scope of the contract negotiation.
- Consider working with the CorneaGen consultant or your own 3rd party consultant for their perspective on the agreement language.
- Carefully consider bundling language – insurance companies are bundling payments for surgery with tissue costs more lately. Make sure that this does not diminish the final payment to the ASC.
- Benchmarking using 3rd party services to see how rates compare to market standard and regional payers.

You can also submit your contract to CorneaGen at [Contracts@CorneaGen.com](mailto:Contracts@CorneaGen.com) for a free comprehensive review and analysis.

## Billing Codes

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

## Common Modifiers

A comprehensive [Global Surgery booklet](#) is available with the latest links to physician fee schedules, global surgery payment rules and any changes to modifiers on the cms.gov website. To find the most recent copy search “global surgery” in the search bar, or follow [this link](#). The 2025 version published December 2025, is available under ICN [#MLN907166](#).

Modifier	Description	Usage
LT or RT	Left Side OR Right Side Procedure	Modifier(s) used for determination of which eye is receiving transplant
-22	Increased Procedural Services	Modifier used when the work required to perform the procedure is substantially greater than typically required. Documentation in the operative report must clearly support the additional complexity, time, or technical difficulty.
-23	Non-Standard Anesthesia	Modifier used when anesthesia is used outside of the standard local anesthesia practices for corneal transplant due to patient necessity. Supporting documentation must justify the deviation from standard anesthesia practice
-24	Patient eval for unrelated procedure	Modifier used when a physician or other qualified healthcare professional provides evaluation services unrelated to corneal transplant during post-op period

Modifier	Description	Usage
-50	Bilateral Procedure	Modifier used when transplant occurs for both eyes in the same surgery session
-51	Multiple Procedures	Modifier used when multiple procedures other than corneal transplant performed in the same surgical session
-59	Distinct Procedure Service	Modifier used when indicating a procedure or service was performed that is independent of other services on the same day separate from the corneal transplant.
-76	Repeat Procedure, Same Physician	Modifier used when corneal transplant procedure needs to be repeated by the same physician
-78	Unplanned Return to Procedure Room	Modifier used in circumstances where the patient has returned to the OR for procedure needs to be repeated by the same physician
-79	Unplanned Procedure by Same Physician Post-Op	Modifier used when a procedure unrelated to the original surgery is performed during the postoperative global period.

## Backbench Preparation

Tissue pre-cut by the eye bank includes the cost of preparation in the invoice charges. 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.

## Frequently Asked Questions Regarding Billing

- **Why didn't I get reimbursed for the corneal tissue?**

If you used V2785 for the corneal tissue and didn't get reimbursed, contact your local Surgical Product Specialist or our Contracts Team for additional support.

The Eyebank tissue invoice is required when submitted to an insurance provider. Ensure you are including the tissue invoice from CorneaGen when submitting for reimbursement.

When billing to Medicare under V2785, ensure your billing includes a KX modifier in addition to the laterality modifier. This modifier indicates that Medicare should be paying the claim at the invoice rate.

- **Based off prior benefits authorization the corneal tissue either is partially covered or isn't covered at all, what do I do?**

Contact your Surgical Product Specialist immediately prior to performing the transplant. Additional resources may be available to assist in this situation.

- **This primer doesn't address my specific problem. What do I do?**

If this primer doesn't address your specific reimbursement problem, please reach out directly to CorneaGen at [Contracts@CorneaGen.com](mailto:Contracts@CorneaGen.com) for a prompt follow up.

**Disclaimer:**

All customers should 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.

## Additional Resources

***Tips and Tricks for Negotiating Contracts with Insurance Companies`***

[www.CorneaGen.com/Tips-and-Tricks](http://www.CorneaGen.com/Tips-and-Tricks)

***Library of Pre-Authorization and Appeal Letters***

[www.CorneaGen.com/Reimbursement/Tissue](http://www.CorneaGen.com/Reimbursement/Tissue)

***The Medicare Claims Processing Manual***

[www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf)