



Corcoran
Consulting
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A Division of Ardare Corporation

Medicare Reimbursement for Astigmatic Keratotomy

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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 Medicare administrative contractors may occur which are not described here. The user is strongly encouraged to review official instructions promulgated by the Centers for Medicare and Medicaid Services (CMS) and its contractors; this document is not an official source nor is it a complete guide on all matters pertaining to reimbursement. In addition, users should check local coverage policies for usage guidelines for the services discussed.*

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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 complication¹ or treat a resulting refractive error due to trauma². 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".

¹ MCPM, Chapter 12, §40.1B

² Transmittal 99

Refractive surgery performed solely to reduce the patient's dependence on eyeglasses or contact lenses would be considered cosmetic in Medi-care'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.

Iatrogenic Astigmatism

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 include: *monocular diplopia interfering with driving and reading, and 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 medical-ly necessary CRI.

Figure 1 Medicare Covered AK Procedure

CASE STUDY IATROGENIC ASTIGMATISM	
Pre-operative Dx:	Clinically significant cataract
Pre-op refraction:	-4.50 +1.25 x 90
Post-op refraction:	-0.50 +4.25 x 95
Patient complaint:	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.

In most states, it is unclear what the criteria are for Medicare coverage of AK due to the absence of local coverage policies on this topic. In cases where coverage is uncertain, an Advance Beneficiary Notice of Noncoverage (ABN) is warranted.

An ABN is a written notice a physician, or other provider, gives to a Medicare beneficiary before items or services are furnished when the physician believes that Medicare probably will not pay for some or all of the items or services.

In June, 2002, CMS published an official ABN form (CMS-R-131-G) which was mandated by HIPAA (PM AB-02-114). A revised ABN (CMS-R-131) became available in March 2008. The revised ABN replaces the existing ABN-G (Form CMS-R-131G) and ABN-L (Form CMS-R-131L). It may also be used in lieu of the NEMB (Form CMS-20007). All providers must begin using the revised ABN no later than March 1, 2009. (See Appendix for sample form)

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.

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 other insurance. Medicaid qualifies as “other insurance” so get an ABN even for dual-eligible patients.

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, formerly optional, is now required. The patient must *personally* choose from Option 1, 2 or 3. 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 for non-covered services.

Pre-Existing Astigmatism

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 opera-

tion, and during the informed consent, ask the patient to sign a NEMB or the revised ABN.

This patient (Figure 3) presents for cataract surgery with significant astigmatism in the pre-operative 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.

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.

Figure 4 **Sample Claim Form for Concurrent Surgeries**

19 Cosmetic surgery exclusion; seeking denial for secondary payer					
21 1. 366.16 Cataract 2. 367.21 Astigmatism					
24a	24b	24d	24e	24f	24g
mm/dd/yyyy	24	66984	1	\$\$\$\$	1
mm/dd/yyyy	24	66999 GY *	2	\$\$\$\$	1

*Included only at the patient's request

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.

DIAGNOSES

Table 1 lists some of the ICD-9 codes that can be associated with AK.

Table 1 **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.

PAYMENT LEVELS

Covered (Iatrogenic)

For covered procedures, Medicare's national payment rates in 2009 for 65772 and 65775 are described in Table 2. The surgeon's reimbursement for 65772 is reduced when the procedure is performed in a HOPD or ASC. Note that payment amounts vary geographically.

Table 2 **Medicare Payment for 65772 / 65775**

	65772	65775
Physician (in office)	\$371.13	\$455.88
Physician (in facility)	\$333.62	\$455.88
ASC ³	\$645.01	\$645.01
HOPD (APC 233)	\$1,105.89	\$1,105.89

Non-Covered (Pre-Existing)

In the vast majority of cases, AK is a noncovered refractive procedure, has no Medicare payment, has no unique CPT code and is an out-of-pocket expense for the beneficiary. The surgeon's professional fee for AK and the associated diagnostic tests may be formulated in two different ways: 1) itemized for each service, or 2) a global package for all necessary services. Such a package might include:

- Refraction
- Contact lens trial fitting in cases of prior refractive surgery
- Corneal topography
- Corneal pachymetry
- AK

³ For further information, please request our monograph, Medicare Reimbursement for ASCs

- Enhancement in case of poor outcome

While some surgeons may decide to charge their patients after each service, others may decide to charge a fixed fee, in advance, for a bundle of services that might be required to obtain the desired result. From the patient's perspective, a fixed fee known in advance is often preferable to an unknown fee with no preset limit.

To derive a global fee, consider the following approach.

1. Assign your usual and customary fee to each service in the package
2. Determine the frequency that each service is likely to occur within the population of patients who elect AK
3. Multiply the frequency times the usual and customary fee to arrive at a weighted average fee for each service
4. Total the weighted average fees to establish the package charge

This approach is analogous to CMS' methodology for establishing relative value units for a procedure using estimates of the time and effort involved.

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 that charge as well as the surgeon's fee.

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 2007, the most recently available data, Medicare only paid for this procedure about 3,850 times; this represents approximately once for every 385

Medicare-covered cataract procedures performed in the Part B system in the same year.

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. If the surgeon always considers AK to be an *incidental* part of the cataract operation (and not separately charged), then the legal stigma is removed. The surgeon's choice is to either (1) always consider AK to be incidental and therefore no-charge, or (2) charge for AK. As long as AK is not used as an inducement for the patient to have cataract surgery, either approach is acceptable.

Whether the surgeon charges for AK or not, the patient must be given informed consent for the procedure. In the case where AK is combined with cataract surgery during the same operative session, the informed consent should specifically address the additional risks, benefits and alternatives to AK apart from the primary procedure.

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 rather than 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

Sample ABN Form

Print your name, address and telephone number. Logo is optional.

Patient Name:

Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items or services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items or services below.

Items or Services	Reason Medicare May Not Pay:	Estimated Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions you may have after you finish reading.
- Choose an option below about whether to receive the _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS:

Check only one box. We cannot choose a box for you.

OPTION 1. I want the items or services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the items or services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment, and **I cannot appeal if Medicare is not billed.**

OPTION 3. I don't want the items or services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227 / TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:

Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Sample NEMB Form

(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

- 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

Sample NEHB Form

(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

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