

Medicare and Corneal Surgery: Cosmetic versus Functional

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INTRODUCTION

With the introduction of several new CPT (Current Procedural Terminology) codes for cornea, corneal coding is in the spotlight for 2004. Many Medicare carriers have LMRP's (local medical review policies) regarding corneal surgery.*

Corneal surgery is similar to oculoplastic surgery, in that it encompasses procedures that can be either cosmetic or functional. Functional procedures usually are covered services for Medicare whereas others may not be payable due to the ambiguous nature of the procedure/diagnoses. Thus, the insurer regards the procedure as cosmetic and, therefore, noncovered. In cornea, the usual reason for this is that the diagnosis relates to a primary refractive error.

REFRACTIVE KERATOPLASTY

Refractive keratoplasty has gained new prominence as a term used for surgery that reshapes the cornea in order to correct refractive errors such as myopia, hyperopia and astigmatism. Do not confuse the use of the word keratoplasty applied to refractive surgery versus the most common usage of the term, which is for corneal transplant surgery.

The HGSA Administrators (PA Medicare Carrier) policy on "Corneal Surgery to Correct Refractive Errors", for example, includes the following procedures as falling into the category of Refractive Keratoplasty:

- Keratomileusis (CPT code 65760)
- Keratophakia (CPT code 65765)
- Epikeratoplasty (CPT code 65767)
- Radial Keratotomy (CPT code 65771)
- Photorefractive Keratectomy (PRK) (CPT code 66999 - the unlisted code)

- LASIK (CPT code 66999 - the unlisted code)
- Conductive Keratoplasty (C.K.)(CPT code 66999 - the unlisted code)

It further elucidates which codes are considered cosmetic and those that are not.

ASTIGMATISM CORRECTION

Medicare only pays for the surgical correction of astigmatism when the astigmatism has been surgically induced or resulted from ocular trauma. The applicable CPT codes are:

- CPT code 65772 (Corneal relaxing incision for correction of surgically induced astigmatism)
- CPT code 65775 (Corneal wedge resection for correction of surgically induced astigmatism).

If neither of these codes is appropriate, then you may have to use CPT code 66999 - the unlisted code. HGSA Administrators wants 66999 used for the reporting of the repair of surgically induced astigmatism resulting from trauma. When coding for repair of surgically induced astigmatism, be very sure to read your own carrier's LMRP. Diagnosis coding plays a critical role in this.

AK/LRI (ASTIGMATIC KERATOTOMY/LIMBAL RELAXING INCISIONS)

AK and LRI surgical procedures performed at the time of the cataract surgery are non-covered and cannot be billed to Medicare unless the astigmatism was induced from prior surgery or trauma. Therefore, many providers are now charging the patient for these procedures. This practice requires close scrutiny on the part of the practice to ascertain if there is medical necessity for the procedure and when it should be performed. Surgical techniques, the amount of preoperative planning and the amount of pre-surgical astigmatism should all be considered before the patient is charged. There would hardly ever be medical necessity for performing one of these procedures whenever cataract surgery is performed.

LASIK

Surprisingly, some carriers do cover LASIK when the procedure is performed for certain qualifying conditions. For payment from Noridian, for example, all of the following conditions must be met:

- Surgically induced astigmatism or anisometropia
- Inability to wear glasses or contact lenses after surgery due the above conditions
- Documented attempts to correct the surgical error with glasses or contact lenses
- Presence of a 2.5 diopter or more increase in the astigmatism and/or anisometropia from the pre to the postoperative state
- Functional disability directly related to the astigmatism and/or anisometropia as expressed by the patient coupled with the surgeon's reasonable expectation that the laser procedure will improve the patient's function
- The patient's primary problem is not corneal graft rejection or multiple failures when the primary goal may be comfort rather than vision improvement
- The laser used must be FDA approved for this indication
- The use of the excimer laser to repair surgically induced astigmatism and or (sic) anisometropia is considered ocular surgery. Coverage is restricted to practitioners who have complied with the regulations of the Food and Drug Administration, are state licensed and is restricted to practitioners with training in the surgical management of the disease or condition being treated per CIM 35-52

ABN (ADVANCED BENEFICIARY NOTICE)

It is always wise to have an ABN signed preoperatively by the patient in the above instances, as well as any others where there may be some questionable postoperative concerns about financial responsibility if the carrier decides to deem the procedure cosmetic and not functional.

NEW CPT CODES - 2004

The new 2004 CPT codes that pertain to cornea coding are:

- 65780 Ocular surface reconstruction; amniotic membrane transplantation
- 65781 Limbal stem cell allograft (eg, cadaveric or living donor)
- 65782 Limbal conjunctival autograft (includes obtaining graft)
- 68371 Harvesting conjunctival allograft, living donor

Amniotic membrane and limbal stem cell transplants are performed to treat many of the following conditions/diagnoses: corneal pannus and/or superficial corneal scarring, persistent corneal epithelial defects, corneal perforation, neurotrophic keratitis, persistent corneal epithelial defects, bullous keratopathy, corneal thinning, corneal ulcer, chemical burns of the ocular surface, pterygia, Stevens Johnson syndrome, limbal stem cell insufficiency, high risk corneal transplants. Of course, this is a catch-all list and only some of these diagnoses apply to only some of these procedures.

MISCELLANEOUS

I caution you not to be overly creative in coding some of these corneal procedures. Instructions in CPT mandate that if there is no code to exactly describe a given surgical procedure then the unlisted code should be used - in this case CPT code 66999. An example of erroneous creativity was the recommendation to use CPT code 65710 (lamellar keratoplasty) for amniotic membrane graft for cases done before January 1, 2004. This would not be acceptable.

If a device is used in surgery that is not FDA approved, then Medicare considers it experimental and the patient is obliged to pay for the operation.

Keratoconus. One of the surgical corrections for keratoconus is the insertion of intrastromal corneal rings. Since there is no specific code for this procedure, you must code it using CPT code 66999.

Deep lamellar keratoplasty. I code this procedure using CPT code 65710 (Keratoplasty (corneal transplant); lamellar. For coders, lamellar keratoplasty refers to removal/replacement of a layer

(lamella) of the cornea whereas penetrating keratoplasty refers to removal/replacement of full thickness corneal tissue.

PTK versus PRK. Phototherapeutic keratectomy is usually a covered service for Medicare and the LMRP's/LCD's set the parameters for coding. Photorefractive keratectomy, on the other hand, is considered a cosmetic procedure and generally is not a covered service. Most carriers process PTK using the unlisted procedure code 66999.

Diagnostic Tests. Pachymetry has received a CPT category I code in 2004 (76514). Many of the Medicare policies restrict its usage to once in a lifetime for glaucoma diagnoses; however, will allow multiple tests when used in various procedures connected to corneal surgery. This is definitely a work-in-progress and the indications, frequency limits, diagnoses, and technologies are all changing in the different policies. For example, the Wisconsin carrier allows pachymetry by laser interferometry to be billed with the CPT code 76514. If not addressed in a LMRP, bill pachymetry by laser interferometry using CPT code 92499.

Corneal topography is reimbursed using the unlisted CPT procedure code for special ophthalmic diagnostic tests (92499). The usual diagnoses that are acceptable for payment are those that involve irregular astigmatism, keratoconus, pre and post corneal transplant surgery. Be sure to check your carrier's LMRP since there may also be very specific billing instructions.

*By December 2005 all LMRP's will be converted to LCD's (Local Coverage Determinations).

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