Who Pays for Health Care?

How should a physician answer a patient's question about financial responsibility for a procedure such as keratoplasty?

BY KEVIN J. CORCORAN, COE, CPC, FNAO

At the center of the current debate on health care reform are two themes, expanded coverage and lower cost. Neither of these goals is new, and it is easy to garner support for them—even within the health care system—until the discussion turns to how reform will occur. The problem is that everyone who wants reform also wants someone else to pay for it. At the core of the argument is the notion of a free lunch. Many people seem to want to believe that health care is a right or entitlement and that it ought to be free or at least cheap. Regrettably, even the richest country on earth cannot afford to pay for unlimited health care for its citizens. Choices must be made—hard ones. Some services are necessary, whereas others are not. Ultimately, patients bear the brunt of these decisions, so it is they who must make them, usually with the advice of their physicians. Even in countries with national health insurance, patients who cannot get free care can elect to go somewhere else and pay for what they want.

How should a physician respond to a patient who asks, "Will my health insurance pay for a particular product or service that you recommend?" It is a fair question but one that implies that health insurance ought to pay for everything a doctor suggests. Although it is understandable that the patient wants insurance to cover the costs, the reality is that health insurance does not pay for a lot of things. The best, most honest and professional answer is, "You need to have this item or service; these other things are 'nice to have' but not essential. Your insurance will help pay for some of the cost, but you'll have to pay for the remainder. Do you want to proceed as I recommended, or do you need more information to decide?" (See *Practice Management Tips* for suggestions on coping with payers.)

In legal parlance, insurance pays for items or services that are "medically necessary." For a carefully worded definition of this concept, see *Medical Necessity Defined*. Table 1 summarizes in plain English the distinction between those things that do and do not satisfy the defini-

PRACTICE MANAGEMENT TIPS

- Investigate the policies of the health plan or third-party payer before surgery.
- Obtain prior authorization from the health plan or third-party payer if possible.
- Notify patients before surgery about their financial responsibility if insurance will not cover the surgery. Get a written agreement.
- Provide financing options for procedures that are not covered.
- Some denied claims or rejections of prior authorization are based on categorizing novel surgeries as experimental or investigational. In that case, the patient is financially responsible.
- A denial of claims may be erroneous. Was the claim correct? Was all the supporting material sent? Follow-up? It may take several attempts to reach a resolution.
- Encourage patients to write letters to their health plans or third-party payers requesting coverage of the surgery. They should also ask for the assistance of their employers' benefits group to lobby the health plan or third-party payer.
- Physicians should speak to the medical director of the health plan or third-party payer and explain why the recommended procedure is more effective, safer, and less costly than any other surgical option. Doctors should back up their argument with evidence-based medicine in the form of well-regarded, peer-reviewed, scientific articles.

MEDICAL NECESSITY DEFINED

The agreement between a beneficiary and his or her health plan states that it will pay for products and services that are "medically necessary," along with a number of other caveats and limitations. According to the *AMA Policy Compendium* (Policy H 320.953[3]),[1] medically necessary means

> *Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily for the convenience of the patient, physician, or other health care provider.*

The Blue Cross/Blue Shield policies use similar language but add that, "except for covered clinical trials, [the services or products are] not for experimental, investigational or cosmetic purposes." Some policies go even further and state, "The Plan may compare the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered." For these purposes, "generally accepted standards of medical practice" means

- Standards that are based on credible scientific evidence published in the peer-reviewed medical literature generally recognized by the relevant medical community
- Recommendations from physician specialty societies
- The views of physicians practicing in the relevant clinical area

1. Ogrod E. Report of the Council on Medical Service: CMS report 13-I-99. Definition of "Medical Necessity." December 1999. http://www.ama-assn.org/ama/upload/mm/372/i99cms13doc.doc. Accessed July 21, 2009.

tion of medical necessity. One murky area is keratoplasty, the focus of this article.

IS KERATOPLASTY COVERED BY INSURANCE? YES AND NO

Keratoplasty includes a wide variety of surgical procedures on the cornea. Some are medically necessary. Others are cosmetic in the sense that refractive surgery is intended to obviate the patient's need for spectacles or contact lenses rather than to help him or her cope with injury or disease. Procedures that are nearly always excluded from coverage include

- Automated lamellar keratoplasty
- Refractive lens exchange
- Conductive keratoplasty or laser thermoplasty
- Hexagonal keratotomy
- Keratomileusis
- Keratophakia
- LASIK
- Minimally invasive RK
- PRK
- RK

Conversely, Table 2 describes keratoplasty procedures that are medically necessary for certain conditions. I recommend checking the payer's local policy for more complete and detailed information. Table 3 provides the pertinent CPT and HCPCS codes.

The surgical correction of corneal astigmatism can be covered or not, because the correction of surgically induced astigmatism is a rare but medically necessary indication. Surgical correction can be achieved in a number of ways, depending on the patient's condition and the surgeon's preference: limbal relaxing incisions, corneal

TABLE 1. WHAT IS MEDICALLY NECESSARY?

No	Yes
Convenience only	To assess or treat injury, illness, disease
Out of the ordinary, not standard	Follows standards of medical care
Unproven, unpopular, unaccepted	Plenty of scientific evidence
Too costly compared with alternatives	Cost-effective

TABLE 2. MEDICALLY NECESSARY KERATOPLASTY

Procedure	Indication
Penetrating keratoplasty	Bullous keratopathy, keratoconus, endothelial dystrophy
Lamellar keratoplasty	Aphakia
Descemet's stripping endothelial keratoplasty	Bullous keratopathy, Fuchs' dystrophy
Phototherapeutic keratectomy	Corneal opacity
Epikeratoplasty	Aphakia, keratoconus, corneal ulcer, corneal degeneration
Corneal relaxing incisions	Surgically induced astigmatism
Corneal wedge resection	Surgically induced astigmatism

TABLE 3. CODES	
CPT Coding:	
65710	Keratoplasty (corneal transplant); anterior lamellar
65730	Keratoplasty penetrating (except in aphakia or pseudophakia)
65750	Keratoplasty (corneal transplant); penetrating (in aphakia)
65755	Keratoplasty (corneal transplant); penetrating (in pseudophakia)
65756	Keratoplasty (corneal transplant); endothelial
65757	Backbench preparation of corneal endothelial allograft prior to transplantation (list separately in addition to code for primary procedure)
65760	Keratomileusis
65765	Keratophakia
65767	Epikeratoplasty
65771	Radial keratotomy
65772	Corneal relaxing incision for correction of surgically induced astigmatism
65775	Corneal wedge resection for correction of surgically induced astigmatism
HCPCS Coding:	
S0800	Laser in situ keratomileusis (LASIK)
S0810	Photorefractive keratectomy (PRK)
S0812	Phototherapeutic keratectomy (PTK)

CASE No. 1. INDUCED CORNEAL ASTIGMATISM FROM PTERYGIUM

	Procedure	Diagnosis
Covered	Pterygium excision with graft	Pterygium
Not covered	LASIK	Astigmatism

CASE No. 2. KERATOCONUS WITH HIGH ASTIGMATISM AND CONTACT LENS INTOLERANCE

	Procedure	Diagnosis
Covered[a]	Intacs	Keratoconus
Not covered	Conductive keratoplasty	Astigmatism

[a]The coverage of Intacs is controversial; some payers consider the procedure to be experimental and investigational. Although the alternative, penetrating keratoplasty, is covered, the Intacs procedure is less invasive and costly, and it has a faster recovery time.

CASE No. 3. PERIPHERAL CORNEAL OPACITY WITH ASTIGMATISM

	Procedure	Diagnosis
Covered	Phototherapeutic keratectomy	Corneal opacity
Not covered	PRK	Astigmatism

relaxing incisions, astigmatic keratotomy, and LASIK procedures. A detailed discussion of reimbursement for correcting astigmatism previously appeared in *Cataract & Refractive Surgery Today*,[1] and a monograph on this topic with useful forms is available on my group's Web site.[2]

With coauthors Hardten and Hira, I previously published an article on the fine line between cosmetic and therapeutic corneal procedures.[3] In that piece, some refractive procedures that usually are not covered could be deemed both therapeutic and medically necessary under some circumstances. They included conductive keratoplasty, LASIK, PRK, and the placement of Intacs (Addition Technology, Inc., Des Plaines, IL). Questions about insurance coverage and patients' financial responsibility are the most difficult when combined procedures are performed that have attributes that are both covered and not and they incidentally provide a benefit to the patient of reduced refractive error.

Some billers suffer from the mistaken notion that any concurrent refractive procedure is bundled with the primary medical procedure and therefore free. This attitude results from restrictions on balance billing beneficiaries. Balance billing is the practice of asking a beneficiary to pay the difference between the actual charge and the assigned benefit amount for covered services that the provider has contractually accepted as payment in full. (For physicians who are not participating with Medicare, the Centers for Medicare & Medicaid Services impose a limiting charge, which is generally less than the physician's nominal charge.) The term does not refer to the collection of copayments and deductibles. Despite the prohibitions against balance billing, third-party payers generally agree that enrollees may be billed for services that are not covered. In this context, it is useful to clearly define and separate services that are covered from those that are not and to obtain the patient's voluntary acceptance of financial responsibility for the latter.

I am presenting three scenarios (Cases 1 to 3) in an effort to help readers appreciate how to parse combined procedures into their covered and not covered components based on the principles outlined earlier.

CONCLUSION

Not infrequently, physicians ask me how to formulate an appeal to a payer so that an item or service will

be covered. This request encompasses a tradeoff: the physician's professional fee for a service not covered is whatever price he or she and the patient agree upon, whereas a covered service is priced by the payer and is almost always less than the physician desires. Ultimately, if all professional services are covered, then everything will be priced by a third-party payer or the government. Clearly, to retain some dignity and autonomy for physicians and to prevent the collapse of the US health care system under the burden of unlimited care for all, patients have to pay for some items and services that are not covered. Readers need only consider the free market for refractive surgery to appreciate the value of that concept. What if LASIK were covered?

In the final analysis, physicians should not object to or appeal every decision that determines that some item or service is not medically necessary and consequently is not covered. Only ill-informed or irrational decisions about essential therapeutic services are objectionable. Elective services, particularly refractive surgery, should not be covered so that they remain unfettered. ■

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