Medicare Reimbursement for Treating Astigmatism

Ophthalmologists need to understand when the surgical correction of astigmatism is and is not covered.

BY KEVIN J. CORCORAN, COE, CPC, FNAO

For patients with operable cataracts and astigmatism, combining cataract extraction with an IOL implant and the surgical correction of astigmatism can reduce or eliminate their reliance on postoperative corrective lenses. Medicare reimbursement is limited to services deemed medically necessary. It does not pay for cosmetic or refractive surgery except in rare instances when refractive surgery may be covered to correct a surgical complication (*Medicare Claims Processing Manual*, Chapter 12, §40.1B) or treat the resulting refractive error due to trauma (Transmittal 99). Refractive surgery performed solely to reduce the patient's dependence on eyeglasses or contact lenses would be considered cosmetic under Medicare and therefore excluded from coverage. Furthermore, according to the *Medicare National Coverage Determinations Manual* NCD §80.7, "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." The surgical correction of astigmatism, by whatever means (eg, limbal or corneal relaxing incisions, astigmatic keratotomy), is a form of keratoplasty and not necessarily a covered service.

IATROGENIC ASTIGMATISM

The *CPT Handbook* describes two procedures to correct iatrogenic astigmatism: CPT 65772 (corneal relaxing incision for the correction of surgically induced astigmatism) and CPT 65775 (corneal wedge resection for the correction of surgically induced astigmatism). In general, wedge resec-

CASE STUDY: IATROGENIC ASTIGMATISM

Preoperative diagnosis:	Clinically significant cataract
Preoperative refraction:	-4.50 +1.25 X 90
Postoperative refraction:	-0.50 +4.25 X 95
Patient complaint:	Contact lens intolerance and poor night vision interfering with driving
Failure of prior treatment:	Spectacles with or without slab off = significant ghosting at distance and diplopia at near. Multiple contact lens trials with poor comfort and manual dexterity problems for patient on insertion and removal.
Postoperative diagnosis:	Surgically induced corneal astigmatism with failure of conventional treatment. Patient complains about restrictions on activities of daily living.
Plan:	Arcuate corneal relaxing incisions

Figure 1. This patient with iatrogenic astigmatism qualified for a Medicare-covered procedure.

CASE STUDY: PREEXISTING ASTIGMATISM	
Preoperative diagnosis:	Visually significant cataract and corneal astigmatism
Preoperative refraction:	-4.50 +2.25 x 90
Postoperative refraction:	-0.50 +2.00 x 95
Postoperative diagnosis:	Corneal astigmatism (not iatrogenic)
Plan	Arcuate limbal relaxing incisions

Figure 2. The procedure for this patient was not covered by Medicare.

tion is used to correct a large amount of astigmatism, whereas 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, the patient's lifestyle-related complaints along with the trial and failure of prior treatment need to be well documented in the patient's record. For example, the complaint might be "monocular diplopia interfering with driving and reading" or "unable to wear contact lens due to poor comfort." The clinical notes would include a discussion regarding a trial of spectacles and contact lenses without success.

The patient represented in Figure 1 experienced a 3.00D increase in astigmatism after cataract surgery. The surgeon should seek reimbursement from Medicare for this procedure. It should be noted that, 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 total of 3.00D, which may justify surgical correction as a covered service.

Few Medicare carriers have local coverage decisions that specify the amount of surgically induced astigmatism required in order to be eligible for reimbursement. In most states, it is unclear what the criteria are for Medicare-covered astigmatic correction. In cases where coverage is uncertain, an Advanced Beneficiary Notice (ABN) is warranted.

PREEXISTING ASTIGMATISM

The *CPT Handbook* does not have a specific code to describe surgery on an eye with preexisting rather than iatrogenic astigmatism. A miscellaneous code (CPT 66999 Unlisted procedure, anterior segment of the eye) is the only one available to describe surgery for this form of refractive error. Medicare claims for refractive surgery to correct preexisting astigmatism will be denied as noncovered services in keeping with NCD §80.7.

Figure 2 deals with a patient who presents with 2.00D of astigmatism postoperatively that was not surgically induced. In this case, the physician should seek reimbursement from the patient for the surgical astigmatic correction. An ABN is not required, but notifying the patient of required payment is in his and the practice's best interest. Before the operation and during the informed consent, the patent should be asked to sign a Notice of Exclusion From Medicare Benefits.

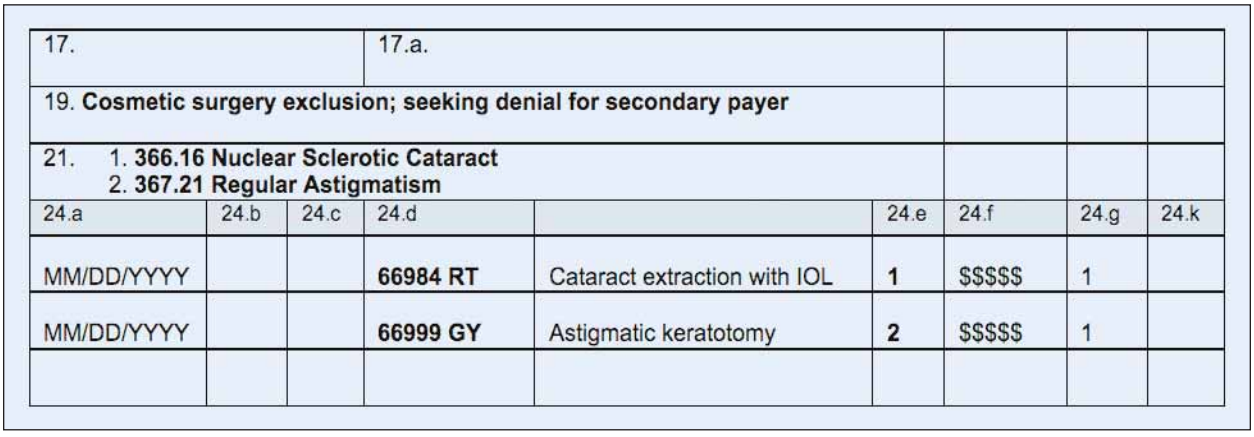
Figure 3 presents an example of a combined cataract and refractive procedure. Despite the large amount of astigmatism in this case, Medicare would only provide reimbursement for the cataract surgery, and the patient would be responsible for the refractive procedure. Again, a Notice of Exclusion From Medicare Benefits but not an ABN would be appropriate. Filing a claim for an excluded procedure (Figure 4) is useful but not mandatory, because the explanation of benefits sent to the patient would show that the surgical correction of astigmatism was not covered. Some patients have supplemental insurance that might cover the procedure, however.

DIAGNOSIS

Table 1 lists some of the ICD-9 codes that can be associated with the surgical correction of astigmatism. Although glasses can often correct regular astigmatism, the presence of anisometropia may require the surgical correction of the astigmatism. Only hard contact lenses and surgery can effectively correct irregular astigmatism. If an eye develops astigmatism (regular or irregular) as a complication of prior ocular surgery and the patient's vision cannot be corrected by conventional means such as eyeglasses or contact lenses, refractive surgery may be indicated. The Medicare claim for a covered procedure includes astigmatism as the primary

CASE STUDY: PREEXISTING ASTIGMATISM COMBINED PROCEDURE	
Preoperative diagnosis:	Visually significant cataract and preexisting corneal astigmatism
Preoperative refraction:	-4.50 +4.25 X 90
Plan:	Cataract extraction with IOL and arcuate limbal relaxing incisions

Figure 3. This patient elected to undergo refractive correction at the time of cataract surgery to treat significant preoperative astigmatism.



17.			17.a.					
19. **Cosmetic surgery exclusion; seeking denial for secondary payer**								
21. 1. **366.16 Nuclear Sclerotic Cataract** 2. **367.21 Regular Astigmatism**								
24.a	24.b	24.c	24.d		24.e	24.f	24.g	24.k
MM/DD/YYYY			**66984 RT**	Cataract extraction with IOL	**1**	$$$$$	1	
MM/DD/YYYY			**66999 GY**	Astigmatic keratotomy	**2**	$$$$$	1	

Figure 4. This patient elects to undergo refractive correction at the time of cataract surgery to treat significant preoperative astigmatism.

diagnostic 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 refractions, corneal topography, and a description of other failed treatments such as glasses or contact lenses.

REIMBURSEMENT

Physician

In 2006, the national Medicare Physician Fee Schedule is 14% lower for CPT 65772 when the procedure is performed in a location other than the physician's office. The lower, nationally allowed amount is $327.07. The allowable for CPT 65775 is not subject to a site-of-service reduction when performed in a facility (Table 2).

Facility

The hospital outpatient department (HOPD) or ambulatory surgery center (ASC) may also charge for the surgical correction of astigmatism. In the typical case involving preexisting astigmatism, Medicare would not reimburse either the HOPD or ASC. The patient would be responsible for those facility-fee charges as well.

For surgery performed to correct iatrogenic astigmatism, however, Medicare would reimburse both the HOPD and ASC. When CPT 65772 and CPT 65775 are performed in an HOPD, they fall under Ambulatory Payment Classification (APC) 233. Medicare's national payment rate for APC 233, effective January 1, 2006, is $872.70 (Table 2). When they are combined with other concurrent surgical procedures, the rules for the reimbursement of multiple procedures apply (ie, 50% for the second procedure).

As of July 1, 2003, CPT 65772 and CPT 65775 were included in the list of procedures for which an ASC facility fee is payable under Medicare's regulations. Under current Medicare regulations, CPT 65772 and CPT 65775 are eligible for reimbursement of an ASC facility fee under group 4, with a national reimbursement rate of $630 (effective April 1, 2004) (Table 2).

UTILIZATION

Refractive surgery and other procedures to correct complications after cataract surgery should be rare. In 2004, Medicare only paid for this procedure 3,750 times; that

TABLE 1. DIAGNOSES AND ICD-9 CODES

Diagnosis	Code
Pseudophakia	V43.1
Postcorneal transplant	V42.5
Regular astigmatism	367.21
Irregular astigmatism	367.22
Complication of corneal graft	996.51
Complication of ocular lens prosthesis	996.53

TABLE 2. MEDICARE PAYMENT

	CPT 65772	CPT 65775
Physician (in office)	$380.49	$455.91
Physician (in facility)	$327.06	$455.91
ASC (Group 4)	$630.00	$630.00
HOPD (APC 233)	$872.70	$872.70

year, Medicare paid for 1.8 million cataract procedures. If complications occur frequently, the Peer Review Organization is likely to investigate the quality of care provided to beneficiaries. Sometimes reimbursement is challenged if the Peer Review Organization believes that the wrong CPT code was used to describe the surgery in order to obtain payment under a false pretense.

LEGAL CONSIDERATIONS

Medicare would object if a surgeon offered free refractive surgery as an inducement for patients to have cataract surgery, and there might be serious legal consequences. Conversely, if the surgeon considered the surgical correction of astigmatism to be an incidental part (and not separately reported) of the cataract operation, then the legal stigma would be removed. For many ophthalmologists, there are enough surgical bundles inhibiting reimbursement. This is one time when the surgeon can choose his fate.

CONCLUSION

The surgical correction of astigmatism alone or combined with cataract surgery provides an excellent means for restoring patients' UCVA. Usually, astigmatism is preexisting and not iatrogenic, and Medicare does not cover the procedure; the surgeon and the facility may therefore charge the patient for the refractive surgery. In a few cases, surgery may be performed to correct a surgical complication, and Medicare will likely cover the procedure. ■

Kevin J. Corcoran, COE, CPC, FNAO, is President of Corcoran Consulting Group in San Bernardino, California. Mr. Corcoran may be reached at (800) 399-6565; kcorcoran@corcoranccg.com. More information on astigmatic correction, including forms mentioned in this article, is available at http://www.corcoranccg.com.