# CROSS-LINKING REIMBURSEMENT: A CASE STUDY IN HOW THE PROCESS WORKS



*Avedro gathered leading refractive surgeons and eye care professionals for a roundtable discussion during the 2018 annual meeting of the American Society of Cataract and Refractive Surgery in Washington, DC. The discussion centered around current issues experienced by ophthalmologists who perform corneal cross-linking in their practices.*


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## COLLABORATING WITH INSURANCE COMPANIES

**Dr. Rajpal:** Reimbursement challenges are common with any new medical procedure. Dr. Lindstrom, describe your experience with insurance reimbursement for corneal cross-linking (CXL).

**Dr. Lindstrom:** This is not the first time we have had to fight this battle in ophthalmology, and physicians have to be involved. At a minimum, we must write supporting letters, and often we need to make phone calls. In my practice, we are encouraging our patients to be aggressive with their insurance carriers, and we are delighted that Avedro is being aggressive.

We are fortunate that major societies—the American Academy of Ophthalmology (AAO), the American Society of Cataract and Refractive Surgery (ASCRS), and the Cornea Society—agree that CXL is a medically indicated treatment for a disease and should be reimbursed by insurers (Figure 1).

**Dr. Rajpal:** Dr. Hatch, what was your experience with reimbursement challenges faced at Massachusetts Eye and Ear, and how did you overcome them?

**Dr. Hatch:** As with any new procedure, we must proactively educate the patients, our community physicians, and the insurance companies. Typically, insurance companies approve the procedure, but then they do not know how to pay for it.

At Massachusetts Eye and Ear, Blue Cross Blue Shield of Massachusetts covered the procedure and many treatments were approved, but we were not being paid initially. The company came to us to make a recommendation for what coverage would be, and we wrote a detailed letter explaining the procedure and emphasizing its benefits.

Initially, the reimbursement rate was disappointing. They were trying to find "treat-like" codes and were comparing CXL to procedures that are not at all comparable, such as pachymetry, removal of epithelium, and phototherapy for vitiligo.

In a call with Blue Cross Blue Shield, we explained that CXL is a ground-breaking procedure that involves a huge amount of chair time. We stressed that we are trying to stop the progression of a vision-threatening disease in adolescents over the age of 14 and that comparing keratoconus to vitiligo is not appropriate.

After that discussion, they set a favorable reimbursement rate, and they are covering both the J and T codes in Massachusetts. That was a success story for us. We are hoping that other insurers will follow, but I think we will have to work with each one individually. It is time-consuming but necessary.

**Dr. Ayres:** Nothing will change unless we help make it change. I have been on the phone for an hour or two waiting to talk to a medical director. In many cases, the director is a family practitioner who has never heard of keratoconus. We have to fight the fight.

## J CODE DECISION

**Dr. Rajpal:** How can we manage some of the uncertainty around the J code?

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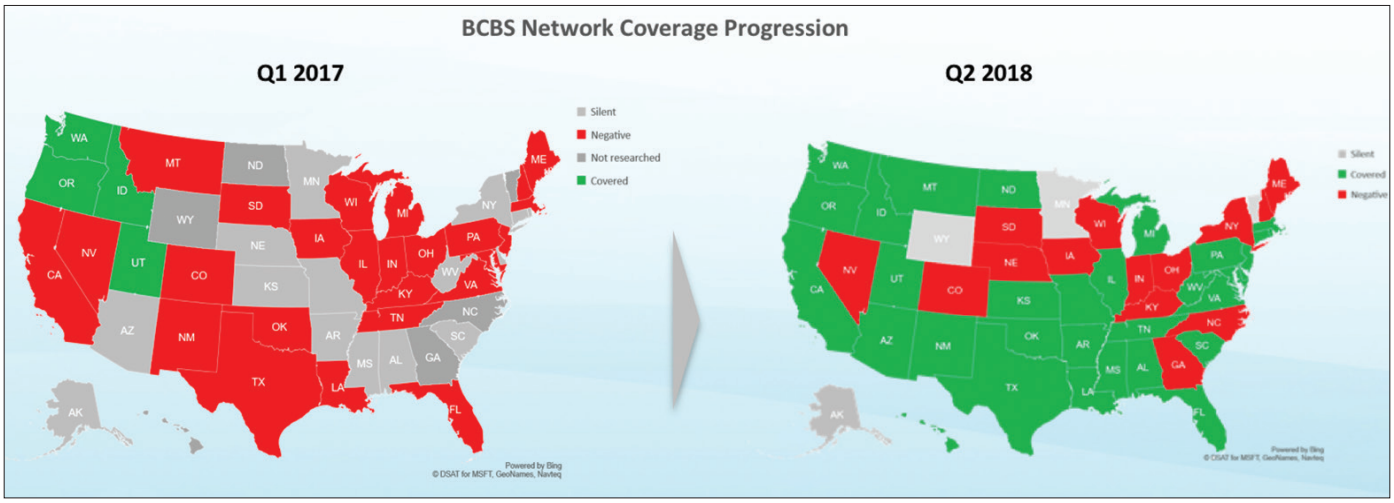


Figure 1. An increasing number of commercial payers begin to recognize the medical necessity of CXL.

**Ms. Rapuano:** I recommend following the suggested guidelines posted on the AAO website (https://www.aao.org/practice-management/news-detail/how-to-bill-corneal-cross-linking).

Basically, you should submit a predetermination letter to the insurer for both the T code and the unspecified J code. By doing this, you can confirm that the insurer is comfortable with the two codes and also that your patient meets the insurer's medical policy guidelines. At Wills Eye, carriers have told us this approach makes sense, because it is similar to our claims for intravitreal injections, where we submit the procedure code and the drug code.

**The Centers for Medicare and Medicaid Services recently issued a preliminary decision to establish a new J code specific to Photrexa Viscous and Photrexa (Avedro), which should streamline the claims submission process. This preliminary decision is expected to be finalized in November 2018 and effective January 2019.**

**For now, current billing practice remains unchanged, and a miscellaneous J code (J3490), as suggested by the American Academy of Ophthalmology, remains an option to bill for Photrexa.**



While payment is not guaranteed, providing the carrier with information up front about the procedure, the cost of the drug, and how you plan to submit the claim is beneficial. Your patients will know that you have gone the extra mile for them. What's more, every claim we submit will help change those policies so that everyone gets access eventually.

**Dr. Rajpal:** Are there legal ramifications we should be aware of?

**Ms. Shuren:** I advise my physician clients to be as transparent as possible with payers to avoid unnecessary audits or allegations of fraud.

The approach Ms. Rapuano outlined is supported by the AAO, and I believe the ASCRS concurs. Hopefully, they will issue written guidelines soon, which is good evidence of what the medical community thinks is the right thing to do.

**Dr. Rajpal:** We have information that the J code has been recommended for approval. Should practices do anything differently?

**Ms. Shuren:** If a new code is issued, it will not be available until January 2019, so just keep using the unspecified code. That continues to feed information into the system until such time as a specific J code becomes available. ■