Billing and Coding Guidelines

Title
Billing and Coding Guidelines for Blepharoplasty, Blepharoptosis and Brow Lift, L34528

Coding Information

1. List the appropriate CPT code for the procedure performed, include any appropriate modifiers.

2. The Medicare global surgery and CCI rules apply to these eyelid surgeries.

3. If bilateral reconstruction is done on the same day, report one line of service using the "50" modifier or report two lines of service with the RT and LT modifiers.

4. List the diagnosis code that best describes the patient's condition. Diagnosis codes must be present on all physician's service claims and must be coded to the highest level of accuracy and digit level completeness.

5. If a patient wishes to have a blepharoplasty or brow lift for cosmetic purposes:
   a. The physician should explain to the patient, in advance, that Medicare will not cover cosmetic eyelid or brow surgery and that the beneficiary will be liable for the cost of the service. Charges should be clearly stated. A claim for cosmetic services does not need to be submitted to the Medicare contractor, unless the patient requests that the claim be submitted on his/her behalf.

   b. When the patient requests the claim for cosmetic services be submitted on his/her behalf, the services should be reported with modifier GY (items or services statutorily excluded or does not meet the definition of any Medicare benefit) **and** diagnosis code Z41.1. The diagnosis code Z41.1 should be placed in the first position in item 21 on the CMS 1500 claim form or the equivalent diagnosis code field for electronic claims. A Notice of Exclusion from Medicare Benefits (NEMB) may be used with services excluded from Medicare benefits.

6. When the signs or symptoms are present: (See "Coverage Indications, Limitations and/or Medical Necessity")
   a. Physicians are encouraged to place the appropriate diagnosis code in the first position with the available symptom diagnosis code in the second position in item 21 of the CMS 1500 claim form or the equivalent diagnosis code field for electronic claims.

7. Visual Field exams are classified as bilateral procedures where the bilateral adjustment does not apply; the Physician Fee Schedule amount represents payment for **both** eyes. The procedure should be reported on a single claim line **without** the 50 or RT/LT modifiers. In the event that the procedure is performed on only one eye per DOS the procedure may be reported with a 52 modifier – (reduced service) and a reduced charge.

8. Photographs are not separately billable to Medicare.

9. *Per CR 10236 - October 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS). This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the October 2017 OPPS update.*

As indicated in Chapter VIII of the CY 2017 National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, CMS payment policy does not allow separate payments for a blepharoptosis procedure (CPT code 67901-67908) and a blepharoplasty procedure (CPT codes 15822-15823) on the ipsilateral upper eyelid. Under this policy, any removal of upper eyelid skin in the context of an upper eyelid blepharoptosis surgery was considered a part of the blepharoptosis surgery. This instruction was clarified in the July 2016 Hospital Outpatient Prospective Payment System (OPPS) Update Change Request (Transmittal 3557, Change Request 9658 dated July 1, 2016) and the July 2016 OPPS MLN Matters Article MM9658.

However, effective October 1, 2017, CMS is revising this policy to allow either cosmetic or medically necessary blepharoplasty to be performed in conjunction with a medically necessary upper eyelid blepharoptosis surgery. Specifically, physicians may receive payment for a medically necessary upper eyelid blepharoptosis from Medicare even when performed with (non-covered) cosmetic blepharoplasty on the same eye during the same visit. Since cosmetic procedures are not covered by Medicare, advanced beneficiary notice of noncoverage (ABN) instructions would apply for cosmetic blepharoplasty. However, medically necessary blepharoplasty will continue to be bundled into the payment for blepharoptosis when performed with and as a part of a blepharoptosis surgery.
Other aspects of the July 2016 OPPS Update CR and MLN guidance on upper eyelid blepharoplasty and blepharoptosis remain unchanged. Specifically, we note that Medicare does not allow separate payment for the following:

** Operating on the left and right eyes on different days when the standard of care is bilateral eyelid surgery*
** Charging the beneficiary an additional amount for removing orbital fat when a blepharoplasty or a blepharoptosis repair is performed*
** Performing a medically necessary blepharoplasty on a different date of service than the blepharoptosis procedure for the purpose of unbundling the medically necessary blepharoplasty*
** Performing blepharoplasty as a staged procedure, either by one or more surgeons (note that under certain circumstances a blepharoptosis procedure could be a staged procedure)*
** Billing for two procedures when two surgeons divide the work of a medically necessary blepharoplasty performed with a blepharoptosis repair*
** Using modifier 59 to unbundle a medically necessary blepharoplasty from the ptosis repair on the claim form; this applies to both physicians and facilities.*
** Treating medically necessary surgery as cosmetic for the purpose of charging the beneficiary for a cosmetic surgery*
** In the rare event that a blepharoplasty is performed on one eye and a blepharoptosis repair is performed on the other eye, the services must each be billed with the appropriate RT or LT modifier.*

Denial Summary
The following situation will result in the denial of initially billed Blepharoplasty, Blepharoptosis or Brow Lift services or in some cases as a result of a postpayment review.

1. Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

   Physicians' services submitted without a diagnosis code or not coded to the highest level of accuracy and digit level completeness will be denied as unprocessable.

2. Title XVIII of the Social Security Act section 1862(a)(10). This section excludes cosmetic

surgery, except as required to repair an accidental injury or for improvement of the function of a malformed body member.

When blepharoplasty is performed to improve a patient's appearance in the absence of any signs and/or symptoms of functional abnormalities, the procedure is considered cosmetic and not covered by Medicare. (Use the GY modifier and ICD-10 code Z41.1 for a non-covered denial.)

Blepharoplasty of the lower lid (CPT codes 15820, 15821) is generally considered cosmetic and will be denied as non-covered.

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06/01/2009

Revision Number Explanation
10/01/2017 Added language from CR 10236 – October 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS) regarding Upper Eyelid Blepharoplasty and Blepharoptosis Repair to the Billing and Coding Guideline.

05/01/2017 Annual review done 04/05/2017. Formatting changes made. Added L34528 from the policy to this Billing and Coding document title. No change in coverage.

05/01/2016 Annual review done 04/04/2016. No change in coverage.

05/01/2015 – Annual review done 04/06/2015 with formatting changes.

05/01/2014 Annual review done 04/02/2014 with multiple typographical and punctuation corrections. No change in coverage.

This document is for J-8 providers in Michigan MAC B 07/16/12, Michigan MAC A 07/23/12, Indiana MAC A 07/23/12 and Indiana MAC B 08/20/2012

04/01/2011: Reformatted and annual review. No changes to coverage (one).