Fact Sheet for Documenting the Need for Functional Blepharoplasty

Before your Medicare Part B patients undergo blepharoplasty, are you sure that you've met all of the payer's pre-op documentation requirements? To help keep your practice audit-proof, use this fact sheet, which is excerpted from *2021 Coding Assistant: Oculofacial* (aao.org/coding products).

The Pre-Op Exam

Medicare Administrative Contractors (MACs) publish local coverage determinations (LCDs), sometimes accompanied by explanatory articles, that describe their coverage policies for blepharoplasty. The Academy posts these at aao.org/lcds.

Tip: Bookmark aao.org/lcds and check it frequently, as MACs can change their LCDs at any time.

At time of press, the seven Medicare Part A/B MACs expected pre-op blepharoplasty exams to include the following:

CIGNA Government Services: Visual field testing at both rest and with lid elevation (taped or manually retracted).

First Coast: "Each eye should be tested with the upper eyelid at rest and repeated with the lid elevated to demonstrate an expected 'surgical' improvement meeting or exceeding the criteria." Photographs required.

National Government Services: Taped and untaped visual fields required. Photographs should also demonstrate the eyelid abnormality (or abnormalities) necessitating the procedures(s).

Noridian: Clinical notes and physical findings, rather than formal visual field testing, should support a decrease in the superior field of vision and/or of the peripheral vision. Photographs required.

Novitas: Photographs required.

Palmetto: Photographs required.

WPS: Visual fields required. WPS emphasizes that photographs are not separately billable to Medicare.

Functional Blepharoplasty Pre-Op Checklist

This checklist meets the current requirements of all MACs. For commercial or Medicaid payers, check their websites.

☐ Functional (not cosmetic) patient complaint. (Note: Don't "clone" notes from patient to patient.)

☐ Appropriate documented physician order indicating which test(s) and which eye(s) are to be tested, plus performance of test(s) required by each unique payer.

☐ Patient's name and date of service on each test(s) required by unique payer.

☐ Physician's interpretation/report of test(s) demonstrating that payer criteria are met for functional surgery.

☐ Margin reflex distance (MRD) measurement.

☐ The patient has been educated by the surgeon about both the risks and benefits of blepharoplasty surgery and about the alternative to surgery. The patient has provided informed consent.

☐ The patient desires to proceed with surgery.

Blepharoplasty Coding Tips

Important: Obtain an Advance Beneficiary Notice of Noncoverage (ABN) and append modifier –GA to the surgical code. You can then charge the patient if the MAC won't pay.

Bilateral surgery. Suppose that you are using CPT code 15823 for repair of the upper eyelid. If repair is bilateral, submit 15823–50, with '1' in the unit field for Medicare patients. Note: Payers who don't follow Medicare rules may require you to bill on two lines, appending either 1) –RT and –LT or 2) –E1 and –E3.

When submitted correctly, payment will be 150% of the allowable.

Cosmetic blepharoplasty. If the patient's eyelid(s) doesn't meet your payer's unique requirements for functional

BY **SUE VICCHRILLI, COT, OCS, OCSR,** ACADEMY DIRECTOR OF CODING AND REIMBURSEMENT, AND **JENNY EDGAR, CPC, CPCO, OCS, OCSR,** ACADEMY MANAGER OF CODING AND REIMBURSEMENT.

surgery, the surgery will be considered cosmetic. Cosmetic claims are not submitted to insurance; however, if the patient insists (or submits the claim on his or her own), it is best to follow these guidelines: Submit either CPT code 15822 or 15823 and append modifier –GY. Use ICD-10 code Z41.1 *Encounter for cosmetic procedure.*

Prior authorization requirements for HOPDs. Do you operate in a hospital outpatient department (HOPD)? Since July 1, 2020, before you perform eyelid surgery or inject Botox (botulinum toxin), you are required to 1) request a prior authorization and 2) receive a provisional affirmation decision. For more information, see "New Prior Authorization Requirements for Blepharoplasty and Botox in HOPDs" (July 2020, Savvy Coder).

Bundling ptosis and blepharoplasty procedures. National Correct Coding Initiative edits continue to have a mutually exclusive bundle with functional blepharoptosis and blepharoplasty procedures.

Stay Up to Date on Your MAC's LCDs

Know your local rules. Every MAC has the discretion to establish specific coverage policies for tests and surgical procedures. Typical LCDs include the date that it goes into effect, a description of each covered service, documentation requirements, and information regarding the ICD-10 codes that do or do not support medical necessity. Some LCDs are accompanied by an article that includes additional information.

Be ready for an audit. LCDs are the rules and regulations by which physicians are held accountable in an audit. Visit aao.org/lcds to learn about your MAC's documentation requirements for the services that your practice provides, and check the site regularly for updates.

See if you can get weekly updates from your MAC. Once a MAC has published its documentation guidelines on its website, it has fulfilled its obligation to keep you informed. Many payers, including Medicare Part B payers, have listservs that provide weekly e-mails notifying you about any updates. Go to your MAC's website and sign up to receive these e-mails. To find the website of your MAC, go to aao.org/practice-management/coding/updates-resources, scroll down to "Medicare Carrier Jurisdiction and Website Addresses," and click the link for the PDF—or go to aao.org/lcds, navigate to the page that lists your MAC's LCDs, and then click on the MAC's name.

Join the AAOE E-Talk listserv. By monitoring the E-Talk listserv, you'll get an early heads-up on how changes in reimbursement policies are impacting practices. Go to aao.org/aaoe and scroll down to the "Listservs" link. To participate, you must be an AAOE member (aao.org/membership/aaoe).