Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Master Oculoplastic Coding with 3 FAQs

Hint: Not all plastic surgeries are considered cosmetic.

Recouping payment for surgeries that could be considered cosmetic can be tough if you code them incorrectly. To help guide your oculoplastic surgery claims, check out the following three frequently-asked questions, along with answers to help you on your way.

Mind the CCI Edits

Question: Can we report blepharoplasty (15823) with repair of blepharoptosis (67908)?

Answer: Not in most cases - payers will typically deny 15823 (Blepharoplasty, upper eyelid; with excessive skin weighting down lid), because CCI bundles it into 67908 (Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection [e.g., Fasanella-Servat type]).

However, you can apply a modifier to separate the edit in cases when the services are unrelated. You'll also assign specific ICD-10 codes (many of which are new for 2019) that denote which eye and lid were addressed. This will help you show the payer that different lids were repaired.

For instance, the surgeon performs a blepharoplasty on the right upper eyelid for dermatochalasis and performs a blepharoptosis on the upper left eyelid for myogenic ptosis. You'll report the following codes:

- 67908-E1 (Upper left eyelid) for the blepharoptosis repair), linked to H02.422 (Myogenic ptosis of left eyelid)
- 15823-E3 (Upper right eyelid) for the blepharoplasty), linked to H02.831 (Dermatochalasis of right upper eyelid).

If your payer doesn't accept the eyelid modifiers, then you'll link modifier 59 (Distinct procedural service) to 15823 rather than using the E1 and E3 modifiers.

Retain the Documentation

Question: We've had a few blepharoplasty claims denied because payers say the procedures were cosmetic, even though we assigned appropriate ICD-10 codes. How can we demonstrate medical necessity for these services?

Answer: Documentation is essential for any service, particularly when there could be confusion about whether the procedure is cosmetic. If you retain all records showing that the service was medically necessary, you can send those notes to the insurer with your appeal.

According to Part B MAC Noridian Medicare, the following records could support medical necessity:

- Photographs of the affected eyelid(s) in both frontal (straight ahead) and lateral (from the side) positions demonstrate either:
  o Redundant eyelid tissue hanging over the eyelid margin resulting in pseudoptosis where the "pseudo" margin produces a central "pseudo-MRD" of 2.0 mm or less, or
  o Redundant eyelid tissue predominantly medially or laterally that clearly obscures the line of sight in corresponding gaze.
- Oblique photos are only necessary if needed to better demonstrate a finding not clearly shown by frontal and lateral photos.

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Keep in mind that if both a blepharoplasty and a ptosis repair are planned (as in Question 1 above), both must be individually documented. "This may (sometimes, but not necessarily) require two sets of photographs, showing a pseudo-MRD of 2.0 mm or less secondary to the redundant skin (and its correction by taping), AND an MRD of 2.0 mm or less secondary to the blepharoptosis," Noridian said.

Many insurance carriers require prior authorization on these surgeries, as they are often considered cosmetic, said **Gina Vanderwall, OCS, CPC, CPPM,** financial counselor with Finger Lakes Ophthalmology in Canandaigua, New York. "Medicare, of course, does not require prior authorization, but the documentation of record must substantiate medical necessity. Some insurance carriers even list blepharoplasty as a 'contract exclusion,'" she says.

It is best to contact the carrier prior to surgery to inquire about their requirements, Vanderwall advises. "They will most likely request records, to include the office visit notes, external photos and Visual Fields (taped and untaped) if you are planning on billing 15823."

Modifiers Are Essential When Splitting Cosmetic/Non-Cosmetic Repairs

Question: Our surgeon is planning to perform a levator resection on a patient's right eye for ptosis. The ophthalmologist wants to do this as a bilateral procedure, but the patient's left eye is a non-seeing eye. Since the operation on the right side may be medically necessary, but the left side would likely be considered cosmetic, how should I code this surgery?

Answer: Report each side of the bilateral procedure on a separate line, appending modifiers LT (Left side) and RT (Right side), linking each side to the appropriate diagnosis code explaining the necessity for the surgery. If you have more specific details (e.g., upper right eyelid, upper left eyelid), you can instead use the eyelid modifiers (E1-E4).

In this case, one side will be medically necessary, while the other will be cosmetic - the procedure will not benefit the vision on the non-seeing eye.

Do this: Have the patient sign an advance beneficiary notice of non-coverage (ABN) prior to the surgery, stating that he is aware that Medicare will not cover the procedure performed on the left eye. Be sure your ABN is in layman's terms and specifies the specific reasons for non-coverage.

You must also specify the estimated cost of the service on the ABN. The original signed ABN indicating the patient's decision (be sure the patient has selected one of the options) to accept financial responsibility, is maintained by the practice and a fully executed copy must be provided to the patient. Append modifier GA (Waiver of liability statement issued as required by payer policy, individual case) to the procedure done on the non-seeing eye to indicate that the patient was informed in advance and has selected the option to be responsible for the non-covered service and unpaid amount.

Example: The patient has congenital ptosis (Q10.0), and his left eye is non-seeing. The ophthalmologist performs levator resection (67904, Repair of blepharoptosis; [tarso] levator resection or advancement, external approach) bilaterally. Code as follows:

- Line 1: 67904-RT linked to Q10.0
- Line 2: 67904-LT-GA linked to Z41.1 (Encounter for cosmetic surgery).

If your documentation shows that the procedure was medically necessary on the right side, Medicare will reimburse the full amount for 67904-RT. The cosmetic diagnosis linked to 67904-LT-GA will prompt the carrier to deny the specific service due to the diagnosis and noncoverage of cosmetic services, and the explanation of benefits (EOB) received by the patient will confirm that the patient is responsible for payment.

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