

Billing and Coding Guidelines

Title

Billing and Coding Guidelines for Blepharoplasty, Blepharoptosis and Brow Lift (OPHTH-022)

Original Effective Date

07/16/2009

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07/16/2012

Text

This document contains the coding guidelines for reporting Blepharoplasty, Blepharoptosis or Brow Lift services and reasons for denial of these services. This article should be used in combination with the Blepharoplasty, Blepharoptosis and Brow Lift OPTH-022 LCD.

Coverage Topic

Cosmetic Surgery; Surgical Services

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 ICD-9 code that best describes the patient’s condition. ICD-9 codes must be present on all Physicians’ 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 carrier, 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 **V50.1**. The diagnosis code V50.1 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. See http://www.cms.hhs.gov/BNI/01_overview.asp#TopOfPage
6. When the signs or symptoms are present: (See OPTH-022 “Indications and Limitations of Coverage and/or Medical Necessity”)
 - a. Physicians are encouraged to place the appropriate ICD-9 code in the first position with the available symptom ICD-9 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 Physicians 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

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 an ICD-9 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-9 code V50.1 for a non-covered denial).

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

Sources

CMS Pub.100-2 16 §20, §120; CMS Pub. 100-4 13 §10, 23 §10-10.1.7

Notes

Italicized font – represents CMS national policy language/wording copied directly from CMS Manuals or CMS Transmittals. Carriers are prohibited from changing national policy language/wording. Providers, through their associations/societies, should contact CMS to request changes to national policy through the Medicare Coverage Policy Process at www.cms.gov/center/coverage.asp

An asterisk (*) indicates a revision to that section of the article.

Other Versions

Publication Date

06/01/2009

Revision, Effective Date/Number/Explanation

06/01/2012 - This guideline is effective 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 08/20/12.

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