BY RIVA LEE ASBELL

Medicare's New ASC Regulations for Ptosis & Blepharoplasty

CMS (Centers for Medicare and Medicaid Services) has issued two very restrictive policies regarding ptosis and blepharoplasty that apply to ASCs, Hospital Outpatient departments, and physicians.[1,2] Societies are addressing their concerns with the regulations; however, it is likely that most of the itemized issues will remain as Medicare regulations/auditing guidelines for performing as well as coding and reimbursement of these procedures. These types of regulations usually emanate from occurrence of multiple instances of what CMS deems abusive or fraudulent (the difference being grounded in intent) coding/billing/reimbursement practices. Many of these untoward practices were probably uncovered in the rash of Recovery Audits conducted in the past few years. I have encountered most of them during audits plus others that are not listed.[3]

Table 1 provides the different introductory remarks contained in each document. The numbered list differs in that the ASC list has one fewer point. I have numbered the points in the Table for ease of reference in this article. The administration of each ASC is obliged to maintain vigilance to ensure that violations of this policy do not occur. Some flaws in the construction of the policies may have been unwittingly executed; nevertheless, extreme diligence is required at this time for the majority of the dictates.

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A Single Procedure Broken into Arbitrary Cosmetic and Functional Portions (Point 3), Different Time Frames (Point 1), Different Stages (Point 5), Different Surgeons (Point 6)

Point 1 must be absolutely adhered to, and ASC administrators should provide direction to all personnel, especially those in charge of scheduling, regarding cases in which this might be occurring or could possibly occur.

The line between cosmetic and functional eyelid surgeries sometimes is indistinct. Nevertheless, the decision has to be made in accordance with preferred practice patterns. Guidance from Local Coverage Determinations from your Medicare Administrative Contractor (MAC) should be followed. If there is none, then use one from another MAC. In any event, Medicare's global surgery policy does not permit an arbitrary division of a single procedure into cosmetic and functional components with the intent of charging the beneficiary for what is deemed as cosmetic.

The prohibition against charging the patient for removal of the nasal fat pad when performing an upper eyelid blepharoplasty procedure in Point 3 must be followed to the letter. I have encountered surgeons who are firmly entrenched in their belief that they can charge the patient extra for this for various reasons (more difficult area to operate in, the fat capsule is encapsulated, requires greater surgical skill to obtain acceptable cosmesis, and so on). From Medicare's perspective, a blepharoplasty procedure includes removal of skin/muscle/fat — nothing can ever be charged to the patient if you are performing a functional surgery. Nor can the surgeon split his fee for a blepharoplasty operation into cosmetic and functional components; neither can the ASC nor the anesthesiologist.

Point 5 prohibits considering blepharoplasty as a staged procedure following ptosis repair. The three uses of modifier 58 (diagnostic to treatment procedure, lesser to greater procedure, procedure planned prospectively) are for physician coding and not ASC coding. Modifier 58

is not used in ASC coding.[4] The admonishment Point 6 of not splitting the two surgeries (blepharoplasty and ptosis) between two physicians is an example of a practice that should not be permitted.

Use of Modifier 59 in Order to Garner Payment for Both Ptosis and Blepharoplasty (Point 7)

The National Correct Coding Initiative (NCCI), also known as the CCI or "bundling lists," is a document that correlates Current Procedural Terminology codes that cannot be billed together to promote correct coding. The objective of the NCCI is to aid CMS in its goal of decreasing fraud and abuse, as well as decreasing the amount of overpayments erroneously being made to providers. The NCCI updates are issued quarterly. ASCs and physicians are under the jurisdiction of the same NCCI documents.

Each code pair has a modifier indicator of 0, 1, or 9 that tells the user whether or not the bundles can be broken, as well as if and when indicated. Just because a bundle can be broken does not mean the modifier should be used to break it. Do not use modifier 59 to break bundles injudiciously.

The blepharoplasty and ptosis procedures are bundled as described in Point 7 and the bundle should not be broken.

Advance Beneficiary Notice of Noncoverage (ABN) (Point 9)

An ABN is a document issued when the providing party (ASC, physician, hospital) wants to notify the patient that he or she will be responsible for given charges outlined in the document if Medicare does not pay for them or if the service is not covered by Medicare. Issuing an ABN is prohibited when two procedures are bundled under the NCCI.

Designating a Medically Necessary Service as Cosmetic for the Purpose of Charging the Beneficiary or Vice Versa (Point 8)

If a patient presents with a functional problem, neither the surgeon nor the facility is permitted to designate it as cosmetic, or potentially not payable by

Table 1: MLN Matters MM9668 & MM9658

MM 9668 July 2016 Update of the Ambulatory Surgical Center (ASC) Payment System

Upper Eyelid Blepharoplasty and Blepharoptosis Repair

CMS payment policy does not allow ASCs to bill for separate payment for a blepharoplasty procedure (CPT codes 15822, 15823) in addition to a blepharoptosis procedure (CPT codes 67901-67908) on the ipsilateral upper eyelid. Any removal of upper eyelid skin in the context of an upper eyelid blepharoptosis surgery is considered a part of the blepharoptosis surgery and is already be [sic] included in the payment rate. Also, ASCs cannot bill a blepharoplasty to Medicare and the beneficiary cannot be separately charged for a cosmetic surgery regardless of the amount of upper eyelid skin that is removed on a patient receiving a blepharoptosis repair because removal of (any amount) of upper eyelid skin is part of the blepharoptosis repair. In addition, the points to the right are not permitted:

MM 9658 July 2016 Update of the Hospital Outpatient Prospective Payment System

Upper Eyelid Blepharoplasty and Blepharoptosis Repair

The Centers for Medicare & Medicaid Services (CMS) payment policy does not allow separate payment for a blepharoplasty procedure (CPT codes 15822, 15823) in addition to a blepharoptosis procedure (CPT codes 67901-67908) on the ipsilateral upper eyelid. Any removal of upper eyelid skin in the context of an upper eyelid blepharoptosis surgery is considered a part of the blepharoptosis surgery. A blepharoplasty cannot be billed to Medicare and the beneficiary cannot be separately charged for a cosmetic procedure regardless of the amount of upper eyelid skin that is removed on a patient receiving a blepharoptosis repair because removal of (any amount) of upper eyelid skin is part of the blepharoptosis repair. In addition, the points to the right are not permitted:

1. Operating on the left and right eyes on different days when the standard of care is bilateral eyelid surgery

2. Charging the beneficiary an additional amount for a cosmetic blepharoplasty when a blepharoptosis repair is performed

3. Charging the beneficiary an additional amount for removing orbital fat when a blepharoplasty or a blepharoptosis repair is performed

4. Performing a blepharoplasty on a different date of service than the blepharoptosis procedure for the purpose of unbundling the blepharoplasty or charging the beneficiary for a cosmetic surgery

5. 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)

6. Billing for two procedures when two surgeons divide the work of a blepharoplasty performed with a blepharoptosis repair

7. Using modifier 59 to unbundle the blepharoplasty from the ptosis repair on the claim form; this applies to both physicians and facilities

8. Treating medically necessary surgery as cosmetic for the purpose of charging the beneficiary for a cosmetic surgery

9. Using an Advance Beneficiary Notice of Noncoverage for a service that would be bundled into another service if billed to Medicare

10. 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 *(note: this appears in Hospital Outpatient document only)*

Medicare, and have the patient pay for it as a cosmetic procedure. I have answered many queries from surgeons who hedge on this issue. The surgeon must decide whether the procedure is truly cosmetic before charging the patient for it.

Worse, do not falsify your operative notes by stating a lower eyelid blepharoplasty is lower eyelid ectropion repair. This would be considered blatantly fraudulent.

Potential Legal Issues (Points 2 and 4)

Points 2 and 4 include time references that require clarification. It is questionable whether it is in the jurisdiction of CMS to prohibit performing a cosmetic blepharoplasty after ptosis repair if it is done within a reasonable amount of time at a later date. These issues are beyond the scope of this review.

The Future

Medical Necessity and Chart Documentation are the key factors in avoiding problems and successfully defending audits. "Blepharoplasty RAC Audits in the ASC" was published in this journal in May 2014 and contains forms for chart documentation that are mandatory to protect yourself.[3] It is highly recommended that you use of a form that facilitates documentation of problems with Activities of Daily Living and ones that document specific problems that are required for surgery to be considered functional by your MAC are highly recommended.

The basic premise of the Medicare program is that each service must be medically necessary and medically reasonable to be a covered service.[5] When documents (such as those recently issued that are discussed here) surface, there usually are a multitude of issues that need correction. It is imperative that you understand the rules and implement the discussed programs. ■

References & Resources

1. MLN Matters MM9658 Revised. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9658.pdf
2. MLN Matters MM9668 Revised. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9668.pdf
3. Asbell RL. Blepharoplasty RAC Audits in the ASC. *The Ophthalmic ASC* – a supplement to *Ophthalmology Management*; May 2014. Accessible at: http://www.ophthalmologymanagement.com/articleviewer.aspx?articleID=111154
4. Asbell RL. ASC Surgical Coding & Claims Processing Potpourri. *The Ophthalmic ASC* – a supplement to *Ophthalmology Management*; October 2015. Accessible at: http://www.ophthalmologymanagement.com/articleviewer.aspx?articleID=113369
5. Asbell RL. Medical Necessity—The Foundation of Medicare Physician Payments. *Administrative Eyecare*. Spring 2012. Accessible at: http://rivereasbell.com/articles/MedNecess.pdf