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Keep Your Eyes Open for Blepharoplasty Post-Payment Claim Review Requests

The Centers for Medicare & Medicaid Services (CMS) has engaged StrategicHealthSolutions, LLC (Strategic) as a Supplemental Medical Review Contractor (SMRC) to conduct post-payment claim reviews of selected Part A and Part B claims for blepharoplasty and other eyelid procedures.

We are aware of several ASCs that have recently received notification from Strategic advising the ASCs that they have been selected for post-payment claims review. Strategic is requesting submission of medical record documentation to support numerous Medicare claims for the eyelid procedures. The ASCs have 45 days to respond to the request.

The post-payment claim reviews respond to a January, 2014 report of the Health & Human Services Office of the Inspector General (OIG) finding state-to-state Medicare coverage inconsistencies for blepharoplasty and other eyelid procedures. Strategic states in its demand letter that while blepharoplasty and other eyelid procedures can be performed to improve abnormal function, reconstruct deformities or enhance appearance, these procedures are non-covered cosmetic services if they are done for appearance purposes only.

Background

CMS delegates to various Medicare Administrative Contractors (MACs) across the country Medicare's claim processing duties. From time to time, MACs publish policies known as local coverage determinations (LCDs) that advise providers/suppliers of certain limitations of coverage that apply to particular items or services. The LCDs are binding on providers/suppliers in the individual MAC's jurisdiction only. Because there can be many different LCDs addressing the same clinical topics, there is state-to-state variation in Medicare coverage for similar items and services.

In its Report OEI-01-11-00500 entitled "Local Coverage Determinations Create Inconsistency in Medicare Coverage," the OIG noted that the various LCDs published among the states inconsistently addressed 134 "clinical topics," one of which was blepharoplasty. The LCDs used different procedure and/or diagnostic codes to address the same clinical topic. LCDs address blepharoplasty in 32 states and although some codes were common across the LCDs, the LCDs used seven different lists of procedure codes and diagnostic codes to describe Medicare's coverage of blepharoplasty.

In response to the Medicare Modernization Act's directive to achieve greater consistency in LCDs, and based on its study, the OIG recommended to CMS, in pertinent part, that it "continue efforts to increase consistency among existing LCDs" and "consider requiring MACs to jointly develop a single set of coverage policies." CMS agreed with the OIG's recommendations. The identification of blepharoplasty

as a clinical topic with inconsistent coverage policies and blepharoplasty's appeal as a cosmetic procedure likely led to the current audit activity.

Types of Information Being Requested

ASCs that receive a post-payment claim review document request are being asked to produce the following information on each case:

- Claim bill
- Physician order
- History and physical
- Relevant signs and symptoms to support indication for procedure
- Photographs showing visual impairment
- Visual field testing measurement with physician interpretation
- Operative report
- Results of pertinent diagnostic tests or procedures
- Signatures/credentials of professionals providing services
- Copies of any patient notices given, *e.g.*, Advance Beneficiary Notice of Noncoverage
- Abbreviation keys or acronym keys used
- Any other documentation to support services

Failure to respond within the allotted time will result in the provider's/supplier's MAC initiating claims adjustments or overpayment recoupment actions for undocumented services. In addition, all medical record entries must be properly signed/authenticated or Strategic will not consider the unsigned proffered documentation.

Practical Takeaways and Recommendations

ASCs should be on the look-out for blepharoplasty medical record review requests and should strongly consider contacting experienced compliance counsel to fashion the best response if they should receive one.

ASCs should review applicable blepharoplasty-related LCDs to ensure that they are billing Medicare in compliance with the coverage provisions. Given that CMS appears to be interested in auditing ASCs' billing practices in this area, ASCs may want to consider performing a self-audit to verify that billing is appropriate. To the extent there is a determination that a non-covered cosmetic enhancement case erroneously was billed to Medicare, the ASC should take prompt action to report and repay the program in order to comply with the Affordable Care Act's 60-day repayment rule. This is essential in order to avoid liability under the False Claims Act's "reverse" false claim provision.

Since the post-payment claim review letters sent by Strategic identifying the items CMS expects to see to justify the medical necessity of the procedure, ASCs may wish to use this as a guideline to ensure their own documentation is complete.

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