

Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift

Policy Number: PG0007
Last Review: 12/01/2023

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

GUIDELINES:

- This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder terms, conditions, exclusions, and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment. Self-Insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise.
- Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards.
- This medical policy is solely for guiding medical necessity and explaining correct procedure reporting used to assist in making coverage decisions and administering benefits.

SCOPE:

☒ Professional
☐ Facility

DESCRIPTION:

Blepharoplasty is a surgical procedure performed on the upper and/or lower eyelids to remove or repair excess tissue that blocks the field of vision causing a functional limitation. Abnormalities of the eyelid that may indicate a need for surgery include excess eyelid skin, droopy eyelids, and eyelids that turn in or turn out. Blepharoplasty is also performed to treat eyelid lesions/alterations due to inflammatory processes such as Grave's disease, blepharochalasis and floppy eyelid syndrome. Blepharoplasty may also be indicated in cases of trauma to the eyelids and orbit. These problems can be unilateral or bilateral and can cause limited vision, discomfort, and affect appearance. Blepharoplasty may, also, be performed for cosmetic purposes.

Ectropion is a turning out or sagging of the upper or lower eyelid. The condition affects the lower eyelid. The sagging lower eyelid leaves the eye exposed and dry. As a result, excessive tearing is common.

If the condition is not treated, crusting of the eyelid, mucous discharge and irritation of the eye may occur. A serious inflammation may result and damage the eye. Corneal dryness and irritation may lead to eye infections, corneal abrasions, or corneal ulcers.

Entropion is an abnormal inward rotation of the eyelid. The relaxing of the eyelid tendons and eyelid muscles results in the eyelid turning inward. When the eyelid turns inward, the eyelashes and skin rub against the eye which can cause watering of the eyes (trichiasis), redness, irritation, or burning. Serious inflammation may lead to damage to the eye. Entropion occurs most commonly because of aging with the weakening of eyelid muscles

Brow ptosis is a condition in which the eyebrow sags or droops. Significant overhang beyond the eyelashes can interfere with vision function or can appear unsightly. It usually occurs bilaterally (both sides) but may be unilateral (one-sided). Causes include aging, thinning tissue on the forehead, paralysis of facial nerves (facial palsy), trauma or disease. Brow ptosis repair is a surgical procedure that raises the brow by removing excess skin and/or tightening lax forehead muscles. This procedure may be referred to as a brow lift or browpexy, depending on the type of surgical technique used.

Blepharoptosis, or ptosis, describes drooping or abnormal relaxation of one or both upper eyelids. It may be due to aging, birth defect, disease, or injury. It is usually caused by a weakness of the levator muscle (muscle that raises the eyelid), laxity of the eyelid skin that occurs with aging or damage to the nerves that send messages to the levator muscle. A blepharoptosis repair is a procedure to correct upper eyelid ptosis. Techniques include levator advancement or frontalis suspension. Severe ptosis may cause visual disturbances impairing peripheral and forward vision. Dermatochalasis (excessive and lax eyelid skin) may occur simultaneously with ptosis.

Thyroid disease may include symptoms of unilateral or bilateral upper eyelid retraction and proptosis (i.e., protruding eye). Most often, medical treatment for the thyroid pathology will resolve these deformities, but occasionally, reconstructive blepharoplasty

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Coverage is dependent on benefit plan language, may be subject to the provisions of a cosmetic and/or reconstructive surgery benefit, and may be governed by state mandates. These services are not covered when performed to improve a patient's appearance in the absence of any signs and/or symptoms of functional abnormalities. Please refer to the applicable benefit plan document to determine benefit availability and terms, conditions, and limitations of coverage.

Paramount Commercial Insurance Plans and Medicare Advantage Plans

- **Lower eyelid blepharoplasty (15820, 15821) requires prior authorization.**
- **Upper eyelid blepharoplasty (15822) requires prior authorization.**
- **Upper eyelid blepharoplasty (15823) requires prior authorization.**
- **Brow ptosis (67900) requires prior authorization.**
- **Upper eyelid blepharoptosis repair (67901-67909) requires prior authorization.**
- **Lid retraction surgery (67911) requires prior authorization.**
- **Ectropion (eyelid turned outward) (67914-67917) does not require prior authorization when the coverage criteria below is met.**

Entropion (eyelid turned inward) (67921-67924) does not require prior authorization when the coverage criteria below is met.

COVERAGE CRITERIA:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

The medical record must contain documented patient complaints and pertinent examination findings to justify the medical necessity for functional, restorative procedure(s) for the treatment of any of the below conditions.

Two digital photographs per procedure (unless criteria specifies otherwise) are required to be submitted for evaluation and determination of a functional visual impairment. Requests submitted without photographs or documentation of visual field test may be denied. *

Visual field testing measures the entire scope of vision by creating an individual map of each eye. With one eye covered, the individual responds to light and/or various intensities of movement by pushing a button, allowing the computer to generate a map of the visual fields. Testing may be completely automated or performed by a technician with or without the assistance of a machine. Testing the central 24 degrees or 30 percent of the visual field is most commonly used. Visual field testing should be performed within the past 12 months. Visual field testing may be completely automated (such as Humphrey Visual Field) or performed by a technician with or without the assistance of a machine (such as Goldmann Perimetry). Both taped and untaped visual fields need to be submitted for each eye for requested surgery.

When multiple procedures are requested the criteria for each procedure must be met.

Lower Eyelid Blepharoplasty (15820, 15821) is considered medically necessary for ANY of the following indications when there is a functional visual impairment as documented by preoperative frontal photographs, may not be an all-inclusive listing:

- Lower eyelid edema due to a metabolic or inflammatory disorder when the edema is causing a persistent visual impairment (e.g., secondary to systemic corticosteroid therapy, myxedema, Grave's disease, nephrotic syndrome, polymyositis, scleroderma, sjogren's syndrome) and is unresponsive to conservative medical management
- Corneal and/or conjunctival injury or disease due to entropion or epiblepharon
- Lid laxity with uncontrolled tearing and/or irritation as documented by history

Upper Eyelid Blepharoplasty (15822, 15823) is considered medically necessary to relieve obstruction of central vision when ANY of the following criteria are met:

- Blepharochalasis, dermatochalasis or pseudoptosis with upper visual field loss of at least 20 degrees or 30% on visual field testing that is corrected when the upper lid margin is elevated by taping the eyelid AND preoperative frontal photographs demonstrate BOTH of the following:
 - light reflex in the cornea with the head upright and the individual looking straight ahead (i.e., not tilted)
 - findings consistent with visual field loss documented on visual field testing
- Difficulty tolerating a prosthesis in an anophthalmic socket (photographs not required)
- Painful blepharospasm that is refractory to medical management (e.g., botulinum toxin injections)
- Orbital sequelae of thyroid disease or nerve palsy (e.g., exposure keratitis)
- Upper-eyelid defect caused by trauma, tumor or ablative surgery resulting in a severe physical deformity or disfigurement which is causing functional visual impairment as confirmed by preoperative frontal photographs

There should be documented complaints within the medical record of interference with vision or visual field-related activities causing significant functional impact such as difficulty reading or driving due to upper eyelid skin drooping, looking through the eyelashes or seeing the upper eyelid skin.

Blepharoptosis Repair (67901-67908) is considered medically necessary to relieve obstruction of central vision when ALL the following criteria are met:

- Upper visual field loss of at least 20 degrees or 30% on visual field testing that is corrected when the upper lid margin is elevated by taping the eyelid
- Upper eyelid margin reflex distance 1 (MRD1) is ≤ 2.0 mm AND preoperative frontal photographs demonstrate BOTH of the following
 - light reflex in the cornea with the head upright and the individual looking straight ahead (i.e., not tilted) OR encroachment of the upper eyelid into the visual field which would prevent the corneal light reflex
 - findings consistent with visual field loss documented on visual field testing

There should be documented complaints with the medical record of interference with vision or visual field-related activities such as difficulty reading or driving due to eyelid position.

UPPER eyelid ptosis (blepharoptosis) repair (CPT code 67901—67908) is considered medically necessary in an **infant or child** less than or equal to seven years of age when there is a:

- Functional visual impairment (congenital ptosis) as documented by preoperative frontal photographs which demonstrate light reflex in the cornea with the head upright and the individual looking straight ahead (i.e., abnormal head posture (head tilt or turn, chin up or chin down), amblyopia, strabismus) OR
- Encroachment of the upper eyelid into the visual field which would prevent the corneal light reflex

The intervention is intended to relieve obstruction of central vision which, in the judgment of the treating physician, is severe enough to produce occlusion amblyopia.

Brow Lift (67900) (repair of brow ptosis due to laxity of the forehead muscles) is considered medically necessary when ALL the following criteria are met:

- Brow ptosis is causing functional visual impairment confirmed by photographs demonstrating that the eyebrow is below the supraorbital rim
- Upper visual field loss, without the brow taped, of at least 20 degrees or 30% on visual field testing that cannot be corrected by upper lid blepharoplasty
- Complaints of interference with vision or visual field, difficulty reading due to upper eyelid drooping,

looking through eyelashes or seeing upper eyelid skin

- Findings consistent with visual field loss documented on visual field testing

There should be documentation within the medical record indicating brow ptosis is causing a functional impairment of upper/outer visual fields with documented complaints of interference with vision or visual field related activities such as difficulty reading due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin.

Ectropion Repair (67914-67917) for eyelid turning outward when the following criteria are met (visual field test not required):

- Chronic symptomatic corneal exposure unresponsive to 12 weeks of conservative medical management (e.g., lubricating drops or ointment); AND
- Functional visual impairment due to symptoms of corneal exposure (excessive drying, tearing, irritation, foreign body sensation, pain); AND
- Injury to the conjunctiva or cornea from:
 - Corneal ulcer; OR
 - Exposure keratitis; OR
 - Keratoconjunctivitis; AND
- A single frontal view photograph confirms the pathology

Entropion Repair (67921-67924) for eyelid turning inward and the following criteria are met (visual field test not required):

- Chronic corneal irritation unresponsive to 12 weeks of conservative medical management (e.g., lubricating drops or ointment); AND
- Functional visual impairment due to epiphora (excessive tearing) and/or ocular pain; AND
- Injury or scarring of the conjunctiva or cornea from either:
 - Symptomatic epiblepharon (extra fold of skin on the lower eyelid that pushes the eyelashes toward the eye) unresolved by growth, in an individual 17 years of age or younger; OR
 - Trichiasis (misdirected eyelash growth toward the eye) unresolved by eyelash removal; AND
- A single frontal view photograph confirms the pathology

Eyelid Repair (67909, 67911) reduction of overcorrection of ptosis ONLY following a medically necessary blepharoplasty or blepharoptosis repair (visual field test not required):

- Correction of eyelid retraction when the following criteria are met:
 - Due to muscular or neurological deficits caused by a congenital defect, disease (e.g., cancer, thyroid disease) or trauma; AND
 - Functional visual impairment due to epiphora and/or ocular pain

A combination of ANY of the above procedures is considered medically necessary when the medical necessity criteria for each procedure are met and BOTH of the following additional criteria are met:

- Visual field testing demonstrates visual impairment that cannot be addressed by one procedure alone
- Lateral and full-face photographs with attempts at
 - brow elevation AND,
 - upward gaze (i.e., with the brow relaxed) support the request
- Findings consistent with visual field loss documented on visual field testing

Coverage Limitations:

- Blepharoplasty, blepharoptosis repair, brow lift, canthoplasty, ectropion repair, entropion repair or eyelid repair for any indications other than those listed above is considered cosmetic and is considered not medically necessary, noncovered.
- Upper and/or lower eyelid blepharoplasty in the absence of a functional impairment or performed for the sole purpose to improve an individual's appearance is considered cosmetic in nature and not medically necessary.

*Where medical necessity criteria indicate need for photographs, photos must be taken with the eyes not dilated
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or squinting. Photos are to be taken at eye level and depicting a frontal view. Photos must be of sufficient quality to show the light reflex on the cornea and demonstrate the lid margins in relation to the pupil. Excess upper eyelid skin, upper eyelid ptosis, or brow ptosis can be present alone or in any combination, and each may require correction. If both a blepharoplasty and ptosis repair are requested, 2 photographs may be necessary to demonstrate the need for both procedures: 1 photograph should show the excess skin above the eye resting on the eyelashes, and a second photograph should show persistence of lid lag, with the upper eyelid crossing or slightly above the pupil margin, despite lifting the excess skin above the eye off of the eyelids with tape. If all 3 procedures (i.e., blepharoplasty, blepharoptosis repair, and brow ptosis repair) are requested, 3 photographs may be necessary.

CODING/BILLING INFORMATION:

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

CPT CODES	
15820	Blepharoplasty, lower eyelid;
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g., banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)
67909	Reduction of overcorrection of ptosis
67911	Correction of lid retraction
67912	Correction of lagophthalmos, with implantation of upper eyelid load (e.g., gold weight)
67914	Repair of ectropion; suture
67915	Repair of ectropion; thermocauterization
67916	Repair of ectropion; excision tarsal wedge
67917	Repair of ectropion; extensive (e.g., tarsal strip operations)
67921	Repair of entropion; suture
67922	Repair of entropion; thermocauterization
67923	Repair of entropion; excision tarsal wedge
67924	Repair of entropion; extensive (e.g., tarsal strip or capsulopalbral fascia repairs operation)
Modifiers	
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Upper left, eyelid
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)
50	Bilateral Procedure

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 11/11/2014

Date	Explanation & Changes
11/11/2014	<ul style="list-style-type: none"> Policy created to reflect most current clinical evidence per Medical Policy Steering Committee
09/23/2016	<ul style="list-style-type: none"> Criteria for lid retraction surgery (67911) added Policy reviewed and updated to reflect most current clinical evidence per the Technology Assessment Working Group (TAWG)
05/26/2017	<ul style="list-style-type: none"> Upper eyelid blepharoplasty (15823) is now covered with prior authorization for Advantage per ODM guidelines Policy reviewed and updated to reflect most current clinical evidence per the Technology Assessment Working Group (TAWG)
04/26/2018	<ul style="list-style-type: none"> Policy reviewed and updated to reflect most current clinical evidence per the Technology Assessment Working Group (TAWG)
12/14/2020	<ul style="list-style-type: none"> Medical policy placed on the new Paramount Medical Policy Format
02/01/2023	<ul style="list-style-type: none"> Medical Policy updated to reflect Medicaid coverage to Anthem as of 02/01/2023
12/01/2023	<ul style="list-style-type: none"> Medical Policy reviewed and updated to reflect the most current clinical evidence Added modifiers E1-E4, RT, LT, and 50
02/01/2024	<ul style="list-style-type: none"> Medical policy placed on the new Paramount Medical Policy Format

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to

<https://www.paramounthealthcare.com/providers/medical-policies/policy-library>

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals> <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs>

- Blepharoplasty (L33944). Local coverage determination. CGS Administrators, LLC.
- Blepharoplasty, Eyelid Surgery, and Brow Lift (L34194). Local coverage determination. Noridian Healthcare Solutions, LLC.
- Blepharoplasty, Eyelid Surgery, and Brow Lift (L34411). Local coverage determination. Palmetto GBA.
- Blepharoplasty, Eyelid Surgery, and Brow Lift (L34528). Local coverage determination. Wisconsin Physicians Service Insurance Corporation.
- Blepharoplasty (L35004). Local coverage determination. Novitas Solutions, Inc.
- Blepharoplasty, Eyelid Surgery, and Brow Lift (L36286). Local coverage determination. Noridian Healthcare Solutions, LLC.

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services <https://www.ama-assn.org/amaone/cpt-current-procedural-terminology>

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets <https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update>

U.S. Preventive Services Task Force, <https://www.uspreventiveservicestaskforce.org/uspstf/>
Industry Standard Review

HISTORY

Paramount Commercial Insurance Plans, Medicare Advantage Plans, and Paramount Advantage Medicaid

Paramount Commercial Insurance Plans and Medicare Advantage Plans

- Lower eyelid blepharoplasty (15820, 15821) requires prior authorization.
- Upper eyelid blepharoplasty (15822) requires prior authorization.
- Upper eyelid blepharoplasty (15823) requires prior authorization.
- Brow ptosis (67900) requires prior authorization.
- Upper eyelid blepharoptosis repair (67901-67909) requires prior authorization.
- Lid retraction surgery (67911) requires prior authorization.
- Ectropion (eyelid turned outward) (67914-67917) does not require prior authorization.
- Entropion (eyelid turned inward) (67921-67924) does not require prior authorization.

Paramount Advantage Medicaid

- Lower eyelid blepharoplasty (15820, 15821) is non-covered.
- Upper eyelid blepharoplasty (15822) is non-covered.
- Upper eyelid blepharoplasty (15823) requires prior authorization.
- Brow ptosis (67900) requires prior authorization.
- Upper eyelid blepharoptosis repair (67901-67909) requires prior authorization.
- Lid retraction surgery (67911) requires prior authorization.
- Ectropion (eyelid turned outward) (67914-67917) does not require prior authorization.
- Entropion (eyelid turned inward) (67921-67924) does not require prior authorization.

Coverage is dependent on benefit plan language, may be subject to the provisions of a cosmetic and/or reconstructive surgery benefit, and may be governed by state mandates. These services are not covered when performed to improve a patient's appearance in the absence of any signs and/or symptoms of functional abnormalities. Please refer to the applicable benefit plan document to determine benefit availability and terms, conditions, and limitations of coverage.

Paramount utilizes InterQual® criteria sets for medical necessity determinations for upper eyelid blepharoplasty (15823), brow ptosis (67900), & upper eyelid blepharoptosis repair (67901-67909).

Lid retraction surgery (67911) is considered reconstructive and medically necessary when ALL the following criteria are present:

1. Other causes have been eliminated as the reason for the lid retraction such as use of dilating eye drops, glaucoma medications
2. Color photograph documents the pathology
3. There is functional impairment (such as 'dry eyes,' pain/discomfort, tearing, blurred vision)
4. Tried and failed conservative treatments
5. In cases of thyroid eye disease two or more Hertel measurements at least 6 months apart with the same base measurements are unchanged

Ectropion (eyelid turned outward) (67914-67917) & entropion (eyelid turned inward) (67921-67924) is covered for all product lines.

COVERAGE CRITERIA

Paramount Commercial Insurance Plans and Medicare Advantage Plans

Paramount utilizes InterQual® criteria sets for medical necessity determinations for lower eyelid blepharoplasty (15820, 15821) & upper eyelid blepharoplasty (15822).

Paramount Advantage Medicaid

Lower eyelid blepharoplasty (15820-15821) & upper eyelid blepharoplasty (15822) are non-covered.

